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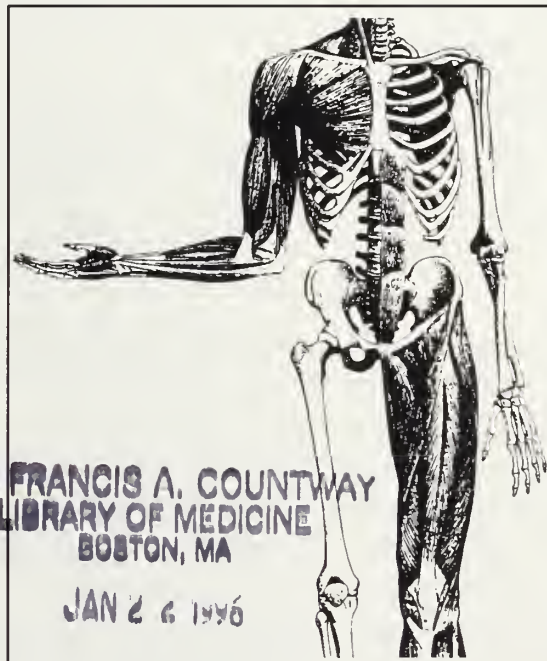
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Scientific articles on medical matters are especially welcomed, including case reports, clinical experiences, observations and information on matters relevant to medical practice. Other material may also be accepted if the editorial staff deems it of interest to *DMJ* readers. All submissions should include a brief summary.

It is highly recommended that authors familiarize themselves with *DMJ* style before submitting manuscripts for consideration.

All material for publication should be submitted either on a 3 1/2" computer diskette in WordPerfect^R 6.0, or typed or printed out on good-quality paper (one side only, double-spaced, one-inch margins). The ideal manuscript length is two to 12 pages. Up to 12 references per manuscript will be accepted, each keyed with superscripts in the text in the order cited. The format should follow that used in the *Index Medicus*. Authors are responsible for the accuracy of the citations.

Graphs, charts and black-and-white glossy photographs are accepted if important to the understanding of the text, but should not exceed four or five pieces. Each should have a label affixed on its back indicating its name, number, and "top." A separate legend should be provided for each. Do not write on the back, or scratch or mar them using paperclips. Do not mount them on cardboard.

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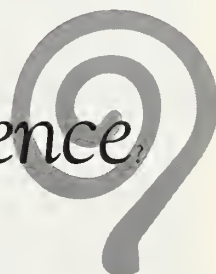
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News From the Front: Highlights of the 1995 AMA Interim Meeting

Having returned yesterday from Washington, D.C., where the AMA Interim Meeting convened, I thought it appropriate and timely to share some of its highlights herein (a more detailed report of actions taken by the House of Delegates will be published in a forthcoming *Journal* issue).

The Hospital Medical Staff Section has redefined itself as the Organized Medical Staff Section, to reflect the trend of de-emphasis of the hospital as the hub of provision of medical care, with the emergence of physician-based delivery systems as an increasingly prevalent phenomenon. Related to this, the Study of the Federation was the topic of an entire reference committee; a major focus of this study was how best to change the very shape of the AMA to reflect its membership and the specialty groups of which it is comprised.

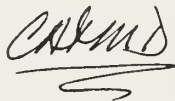
Medicare reform was a major topic of discussion. In October, the House of Representatives passed the Medicare Preservation Act, which 1) would allow for the formation of provider-sponsored organizations and physician service networks; 2) included health care liability reforms, with a cap on noneconomic damages; and 3) provided considerable regulatory relief regarding physician referrals ("Stark I and II") and also modifications to the Clinical Laboratory Improvement Amendments (CLIA). These important inclusions were present largely thanks to AMA input and lobbying efforts. In the Joint Conference Committee however, the Senate voted to drop

the antitrust relief provision, remove the CLIA modifications, and the liability reforms were deleted, because of the "Byrd Rule," which stipulates that any actions which do not directly involve changes in mandatory spending cannot be part of a reconciliation bill. Recently, as was anticipated, the president vetoed the Conference Report. Thus it now becomes critical to press for these important changes to occur. Members of your delegation went to Capitol Hill and met with representatives of Senators Roth and Biden and of Congressman Castle, to ensure that the Society's voice on these issues was heard.

Managed care issues continued to consume a great deal of the House's attention. One could only be impressed not only with the need for continued efforts toward patient advocacy, but mainly with the need for physicians to regain control of the practice of medicine. Discussions were replete with grim examples of obstacles to optimal or even decent patient care, such as the inclusion in some managed care contracts of "gag" rules, provisions which prevent physicians from telling their patients of their disagreement with a managed care organization's decision to deny a service, and of "hold harmless" attempts to shift responsibility for outcomes of such decisions from the managed care organization to the physician.

A myriad of other issues addressed could be described. The importance in all of this of the need to set aside our individual self-interests and to organize ourselves into a unified, well-

coordinated, powerful entity, not only to fight against and rectify what is wrong, but to create what is moral and right, and preserve above all else the welfare of our patients and the freedom to render the kind of care they deserve and we believe in emerges, at least in my mind, as I participate in this process, as paramount. Your leadership will continue to move forward in this direction, but as always, needs your help.



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SCIENTIFIC ARTICLE

Annual Scientific Program Summary Medical Society of Delaware Saturday, November 18, 1995

The Annual Meeting of the Medical Society of Delaware (MSD) was held Friday and Saturday, November 17 and 18, 1995. The Friday sessions were chiefly the business side, with discussion panels reviewing reports on all aspects of MSD operations, followed in the afternoon by the meeting of the House of Delegates. These reports and actions will be published in our Journal in January and February.

There was one presentation on Friday, November 17, 1995 on HMOs, and then the scientific sessions on Saturday, November 18, 1995. These, as usual, I have attempted to summarize in the following pages. The Program Committee always seems to select excellent speakers, and topics of general interest and importance. This year was no exception. It was interesting and enlightening. I hope that those of our members who were unable to attend will get some of the flavor as well as the information from these summaries. — EWM

The 206th Annual Meeting of the Medical Society of Delaware was opened as usual with a breakfast for all delegates, hosted by the New Castle County Medical Society. The lead-off speaker was Michael Lance, a CPA and now CEO of PMSCO, a management and consulting agency started by Pennsylvania Medical Society to help doctors with the transition to managed care.

In the northeast United States, the payors (insurers) have the leverage to coerce doctors into contracts favorable to the payors but not necessarily to the patients and certainly not to the doctors. If the medical profession is willing to take the risks and start its own Physician Organization (PO), this leverage will begin to shift to physicians. The PO will permit physicians to contract with the HMOs to assume and manage capitation and risk for the physician component of the premium, and obtain the ability to manage and receive surpluses from the HMO hospital and pharmacy pools. The goal would be to have HMOs competing for doctors — not vice versa. If we are to do this, we must define our health care community and join together to form our PO to serve it. Doctors should remain as free

agents, joining as many HMOs as they wish. Patients will keep their own physician if they have a chance to do so, and this would give them that opportunity.

Although HMOs may seem like “the bad guys” to many physicians, they are here to stay and we can live with them, with minimal disruption to physician practices. It is an innate characteristic or function of HMOs to ratchet down fees. If POs are organized and run properly, POs can save very adequately on hospital and pharmaceutical costs to make the operation worthwhile.

Mr. Lance indicated that physicians in any community tend to be independent and fragmented and unwilling to commit themselves to take financial risks, so in developing POs they tend to form around hospitals or insurance companies which do have funds and can take risks. However, the insurance companies have no intention of giving the doctors any equity, and are committed to giving any surplus (i.e., profits) to their shareholders. If they can sign a doctor to an exclusive contract or even control 30 percent of his or her practice, they control him or her, and all the doctor has left is a contract. The doctor

must dance to their tune, and can be moved out at any time. Forming a PO around a hospital may be a preferable way to access assets, but consider: 1) In the new order, hospitals will be squeezed and struggling and many will close, 2) Hospitals are being bought, sold and merged by larger financial interests, including insurance companies, 3) Hospitals have a conflict of interest if the HMO is trying to reduce costs by reducing hospitalizations and the HMOs know this, 4) Being tied to one hospital reduces your options and the patients you appeal to. Better by far is for physicians to form their own POs.

This, of course, entails not only financial risk but also risk of antitrust action. However, it appears that if doctors in the PO are assuming the financial risks (as by capitation), and if initial membership solicitation in the PO is open to all without restriction, there is little to fear in that regard.

In setting up a PO, the doctors become the shareholders, with one share and only one to each doctor. A board of trustees is formed which by law has a fiduciary responsibility to the shareholders and should ensure that about 55 percent of the premium dollars go to the doctors. The other 45 percent will go to hospitals. If hospitals are part of the organization (a PHO), there is a tendency for the hospital to absorb any surplus. If it is purely a physician organization (a PO), any surplus becomes a dividend to shareholders. The PO should initially be open to all doctors in the defined community, but the Board of Trustees must have a majority of primary care physicians. There may be some doctors who seem outliers and not accustomed to thinking in terms of economical practice, but all are able to learn, and they must be taught.

The PO works best if it is multispecialty and includes a large number of primary care physicians. By forming a PO, physicians can maintain their autonomy, as well as their referral patterns. To develop new referral patterns always entails some risk — the risk of the unknown. A major tenet of the HMO practice is to keep costs down. The national figure of 450 hospital days per year per 1,000 subscribers should be capable of reduction as low as 150 days per year, a third of its previous level and the largest source of savings. Once

the patient is in the hospital, specialists control 70 percent of the costs and they are out of the control of the HMO. It is important not to withhold care, and that means highest quality care. If the doctors running the care are paying attention to make sure things happen on time, as they should, hospital days and therefore money will be saved.

Mr. Lance spoke rapidly but clearly and well. He had many one-liners, quips, slogans, words of advice, referring to "mature managed care markets" (which we are not), and "never sign an exclusive contract." He referred to POs and PHOs, which took a while for me to figure out.

One of his best, "Don't sell your practice" (continue working in it for a salary). It controls your decisions, curtails your options and income. You'll be sorry within a few years.

Management of Stroke

Speaker: J.P. Mohr MD, Sciarra Professor of Neurology, Columbia University College of Physicians and Surgeons, New York, New York.

Most of us who are more than five years out of medical school were taught that there is not much we can do about strokes except try to rehabilitate the patients after the damage is done. Dr. Mohr indicated that recent work holds us to a higher and more hopeful standard, and we can no longer say, "It's not my fault." Not only can we take steps to prevent recurrent stroke, but we can also act effectively for primary prevention in high risk people and even modify the neurologic loss in strokes-in-progress if seen in the first 12 hours.

The risk of recurrent stroke can be reduced by 30 percent with aspirin or similar medications (dipyridamole or ticlopidine). Even more effective, low-dose warfarin is relatively easy, safe and inexpensive if we don't try to push to full anticoagulation, and it lowers risk by 70 percent. Dr. Mohr described a novel double-blind multi-hospital study he is running to define this further.

Oral calcium channel blockers (e.g. Nimodipine — Nimotop®) are useful in reducing the loss of nerve cells in the first 12

hours of a stroke, though not thereafter. A neurologic deficit that persists after three hours is not a transient ischemic attack (TIA) but a stroke, so there is a narrow window of opportunity between 3 and 12 hours.

In low-risk asymptomatic patients with 60 percent or greater carotid stenosis, surgical correction in good hands lowers the five-year risk of stroke from the 10.6 percent expected from medical management to 4.9 percent, a 55 percent reduction ($p = 0.006$, CI 95 percent).

Neck vasculature provides another basis for thromboembolic stroke following injuries which may seem minor. He described a syndrome of headache, Horner's syndrome and dyslingua culminating in a full-blown stroke. These patients at the very least merit a Doppler study and treatment with aspirin.

Finally, Dr. Mohr described a syndrome of brain infarcts large or small resulting from a patent foramen ovale. Some feel that up to 40 percent of strokes of indeterminate origin may be related to this and correctable by closure of the foramen.

In brain scans that rely on computer analysis of signals (CAT, MRI, and PET) the way the computer is programmed can produce images (or deletion of images) not representative of the true functional anatomy. The person reading the scan must have sufficient clinical history to be able to avoid these pitfalls in interpretation.

Risks and Benefits of Hormone Replacement Therapy

Speaker: Bruce Ettinger MD, Senior Investigator, Division of Research, Kaiser Permanente Medical Care Program, Oakland, California; Clinical Professor of Medicine and Radiology, University of California Medical Center, San Francisco, California.

According to Dr. Ettinger there are four basic reasons for giving estrogens to post-menopausal women and four reasons not to. Although many women look upon estrogens simply as a way of ameliorating or avoiding menopausal symptoms, much more compelling reasons exist: slowing skeletal bone loss, reducing the risk of coronary heart disease and

reducing atrophic genito-urinary changes. These must be balanced against costs, side effects, gyn problems (such as bleeding) in some women, and some increase in cancer risk (endometrial and breast). It became clear that Dr. Ettinger felt it was worth the risk.

Osteoporosis is a disease or pathologic condition that has its beginnings in the early 30's with a negative calcium balance that loses about 0.5 percent of skeletal mass per year, accelerates after menopause and eventually slows in the patient's 80's and 90's, but never really stops. Bone density correlates with fractures, chiefly hip and vertebrae, but also radius, and the relative risk (RR) doubles with each standard deviation of bone density loss. Estrogen slows the bone calcium loss but never really stops it. Substantial calcium intake (1000mg/day) increases the effectiveness of the estrogen, permitting relatively smaller doses. The target is an estradiol level of 50 picograms. The estrogen should be continued indefinitely. Stopping it leads to an increased rate of loss that within a few years produces a total loss comparable to what would have been if the patient never started it.

The cardiovascular effect of estrogens is more complex. The peak age for myocardial infarctions in women is 74, presumably the result of a rise in total cholesterol and a fall in high density lipoproteins (HDL) after menopause. Estrogen replacement quickly raises the HDL. Low-density lipoproteins (LDL), when oxidized, damage vascular intima, leading to plaques, but HDL opposes that action. Estrogen is an anti-oxidant which also deters or prevents this from happening. In addition, estrogen tends to relax coronary artery tone, an immediate effect which translates to improved exercise tolerance and a 40 percent reduced risk of coronary occlusion. Changes in mortality take longer to show up but are evident after 5 to 10 years as a 50 to 75 percent reduction. Thus there is an immediate effect on spasm and a long-term effect on the atherosclerotic process.

On the negative side, there can be no doubt that estrogens produce endometrial hyperplasia or atypia in up to 20 percent of women. This, of course, is negated by a history of hysterectomy. For the past 10 to 20 years, gynecologists have

tried to oppose the estrogen with progesterone given by any of several intermittent protocols, all of which reduce the effectiveness of the estrogen slightly and have some tendency to produce bleeding and menopausal symptoms. This becomes a juggling act testing the clinician's judgement and persuasive powers, and guided by the urgency of the need for cardiac and/or skeletal protection. However, unopposed estrogen is too big a risk for women with an intact uterus given over any long period of time. Breast cancer seems to be more of a concern to most women. Dr. Ettinger would not use estrogen in the face of a history of breast cancer, and would be hesitant if there were a history of a genetic predisposition for *early* breast cancer, but otherwise tends to go ahead with the estrogen/progesterone relying on careful patient education, explanation and periodic screening.

In the country as a whole, about 30 percent of post-menopausal women use estrogens, but the average duration is only about 10 months. Why do they stop? Reasons given are: 1) "Don't need it any more" (assuming it was given for hot flashes) 2) "I'm not sure the benefits outweigh the risks," and 3) "Side effects."

Advances in Cancer Gene Therapy

Speaker: Stephen L. Eck MD, PhD, Director of Cancer Gene Therapy Programs; and Anne B. Young Assistant Professor of Medicine, Division of Hematology/Oncology, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania.

Ever since the discovery of the spiral of DNA scientists have been fascinated by the possibilities of gene therapy. If they could only modify or replace the DNA at a cellular level, they could make the cell do what they want — produce the normal protein, replace the missing enzyme — and thereby correct all manner of genetic disorders.

But how do you get the new DNA into the cells — that is the cells you wanted. That's not easy. You must first have a vehicle for doing this, but the gene molecule is many times larger than any pharmaceutical vehicle. Perhaps a virus could do it. After all, a virus is

only DNA wrapped in a protein shell, and the normal activity of viruses involves getting into the cells. Perhaps a retrovirus — that stays in cells. But no, a retrovirus only gets into dividing cells, and it has other potential disadvantages. Then, how about an adenovirus? That might work, but the body might recognize it as foreign and develop an immune response to the virus. Maybe if we disguise the DNA by wrapping it in something. How about a liposome or fat globule? It is an appropriate size, and layered like an onion, so a liposome could hide the DNA inside.

Once the delivery of the DNA has been achieved the problem becomes deciding the sequence of the DNA. We may want to modify the DNA sequence to minimize its toxicity. An alternative approach to using viruses would be to design a DNA delivery vehicle from scratch. Sadly, this has proved to be very difficult to do and so far only works in cultured cells but not in animals. When we finally get the DNA delivery system we want, how do we go about getting the vehicle only into the specific cells we want? That is about where we are at present.

A good example is cystic fibrosis. This disease results from a defect in a transport gene that regulates salt and water balance. They have tried instilling an adenovirus containing the cystic fibrosis gene by a bronchoscope into small terminal airways. But unfortunately as far as anyone can find out, this has not resulted in any significant gene transfer.

On a happier note, using a disabled retrovirus vector, in a few patients with adenosine deaminase deficiency, a severe combined immunodeficiency syndrome, they incubated the desired viral vector with the patient's T lymphocytes. These lymphocytes were then infused into the patients and appeared to produce a clinical response. These patients are now being monitored to see if there are any lasting benefits. There now are more than half a dozen gene therapy vehicles that are being clinically tested.

Of course it is difficult to get cells to change their behavior. A simpler goal might be to deal with abnormal cells, such as cancer cells, and get them to accept a DNA incompatible with

their life. This work is being tested at the University of Pennsylvania using two types of malignancy that only spread by direct extension. Mesothelioma and glioblastoma are tumors that do not metastasize to distant sites. For both of these tumors investigators at the University of Pennsylvania are using a herpes virus gene which has a known ability to kill cancer cells. They are using an adenovirus to deliver the herpes gene into these tumor cells. Patients then receive intravenous ganciclovir. The tumor cells that have the new gene metabolizes the ganciclovir to a toxic form, and this causes them to die. If even a small percentage of tumor cells take up the new gene they can disseminate the toxic form of ganciclovir to other tumor cells and eventually kill all of them. So far this has been shown to work in rodents, and is being tested in patients with these cancers.

Other efforts use gene therapy to induce a vaccine response to the tumor. In animals, a combination of interleukin 12 and B7 has been effective in vaccinating against melanoma and breast cancer. However this has not been tried in humans as yet. Although the strategies are complex, when the key is found its likely production and introduction into patients should not be difficult, expensive or toxic. Meanwhile the work goes on, so near and yet so far.

State and National Concerns with Teenage Pregnancy

Speaker: Henry W. Foster Jr., MD

The luncheon speaker in the position of honor after the scientific meetings was Dr. Henry W. Foster Jr, former dean and now professor of obstetrics and gynecology at Meharry Medical College, Nashville, Tennessee; where voting on his appointment as surgeon general of the United States was blocked by the anti-abortion forces in the Senate. Dr. Foster has devoted virtually his entire life to trying to solve the teenage pregnancy problem and associated high infant mortality, single parent families and social and physical ills of primarily impoverished African Americans. He has developed, among other things, some pilot

programs in his home city of Nashville, Tennessee which seem to work; especially one known as *I Have a Future*.

Dr. Foster, with a convincing show of demographics, was able to make it very clear that teenage pregnancies are not just a problem of blacks. Of all the "industrialized" nations of the world, the USA is the only one with significant numbers of pregnancies in 13 to 14 year-olds and clearly outstrips all others in total teen pregnancies to unwed mothers, almost two fold the other countries. This is true regardless of race. It is not due to difficulty getting abortions, as our abortion rate is also the highest. Moreover, sexual activity is not earlier here than in other countries.

He has attempted to define the social and psychological antecedents of this phenomenon and believes it is largely because a significant number of these young women *want* to get pregnant. They see it as the only meaningful way out of a difficult life pattern, a means of obtaining identity, demonstrating courage and expressing their angry defiance of a society that is loveless, hopeless and uncaring. As he expressed it, they act on misinformation out of a poor self image, feelings of failure, and an unmet need for love and nurture. They have not matured enough to consider the consequences of their actions, and feel they have no control over their lives. And this pattern feeds on itself and repeats, generation after generation. The solution, as Dr. Foster sees it, is to provide another focus at this time in their lives, other activities, other options that are achievable. There are barriers to this, not just financial but attitudinal and organizational, and the way these play out for the individual child determines the outcome.

As he set up his program, he saw it clearly needed a residential venue. It had to be set up in the community housing projects, and it had to involve the families and the community at large in a network of caring. It had to recognize the barriers and reduce them. It had to be open to all adolescents, had to address idle time, (especially 3 to 7 p.m. when most of their pregnancies originate). It had to relate to the schools and homes in a realistic manner. It had to address the role of the males, address culturally appropriate beliefs and attitudes,

measure sexuality and family life attitudes over sufficient time span to effect change. It had to address not only the capacity to change but equally important, the *desire* to change.

He set up an advisory council with representatives from many different walks of life including business, clergy, civic organizations, media, schools, youth groups, government, social organizations and higher education. Their interventions included counseling, teen health sessions, social activities, skills development and parent-family development. They tried to improve knowledge of personal health and thereby change attitudes and behavior (e.g., contraceptive use). They organized field trips of all kinds, not only to zoos and public attractions but to industrial and commercial enterprises — anything to expand the exposure of the teenagers, most of whom had never been out of their own immediate neighborhoods.

Initially many of the attitudes they encountered, particularly among the males, were scornful, belittling, intimidating, but as time went by and the nay-sayers saw the exposure and involvement of their peers, they also wanted to be involved. Those working on the project make every effort to avoid a negative approach, and keep things positive. Don't say "You're wrong," but rather, "There are different ways of doing that. Here's another way." He considered it important that there be white people involved and that the youth see them in a positive role as well. For most of the teenagers, they had never seen white people except in negative roles — evicting them from their homes, arresting them and taking them away, repossessing their cars, disciplining them.

Finally he listed the principles of blackness which they teach to bolster feelings of pride and self-worth. I noted that black people around me seemed very familiar with the list, but I was not. I'll try to learn it: creativity, faith, purpose, cooperation, unity, self-determination, work and responsibility. There may have been more that I missed. But the solution that must be the guiding motto of the whole project of *I Have a Future* must be "Do something else." Having a baby is not a solution for teenagers who have not completed their education.



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Why Should Physicians Worry About Patient Satisfaction? **Applying Some of the Principles Used in the Emergency** **Department to Hospital and Office-Based Practices**

Sara F. Sutherland MD
Robert E. O'Connor MD

Introduction

Many of the principles used to attain customer satisfaction in emergency medicine can be applied to a variety of settings. Acute illness may occur in patients having a long-standing association with their physician, thereby changing the dynamics of the relationship. With changing practice patterns, patients are changing physicians more frequently, and physician groups are getting larger, often encompassing multiple specialties and myriad arrangements for emergency coverage. The shift to outpatient care has resulted in increased acuity for hospitalized patients. The days of admitting patients for "observation" or on request (and getting reimbursed) are over.

Many of these revolutionary changes in medical practice can impact the degree of patient satisfaction. In addition to using sound medical principles, physicians must pay particular attention to spending adequate time with the patient, not forcing them to wait unnecessarily, answering questions thoroughly and addressing family concerns. While, arguably, the patient is a patient and not a customer, failure to attend equally to the patient's medical, psychological and social needs can impede therapy.

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In this paper, we use the emergency department as a model for employing strategies to promote patient satisfaction, in the hope of promoting their full participation in their care. The emergency department was chosen because patients arrive following some sudden, often catastrophic event, and most are seeing the treating physician for the first time. These factors, coupled with the transient nature of treatment, encourage strategies aimed at developing quick rapport, addressing medical as well as psychosocial issues and explaining anticipated treatments thoroughly. While primarily developed in the emergency department, many of these principles can be tailored to suit a variety of practice settings.

"I Can't Get No Satisfaction"

Patient satisfaction has been used as an indirect measure of quality of care, often perceived as being vital to the bottom line for both the physician and the associated hospital. However, consistent attainment of a high degree of customer satisfaction can be an elusive goal, since many factors inherent to the practice of medicine during times of crisis can make consistent customer satisfaction difficult.

By definition, most patients seeking emergency care have had some abrupt, unanticipated injury or illness that, if ignored, may result in significant pain, disability or death. Such an ailment forces them to drop

what they are doing and seek immediate care. This disruption of their plans, combined with the seriousness of their illness, puts a negative cast on the encounter from the beginning. Any perception of slight or inconvenience (long waiting times, indifferent staff) will amplify this negative feeling. If this situation is not ameliorated, it is very easy to accumulate many unhappy patients, and their family members, in an emergency department. To offset these negative aspects of the visit, it is vital to the success of the department to create a working environment that will encourage and cultivate customer satisfaction.

One Solution: Get Happy

The first required assumption is that patient satisfaction cannot be achieved in the absence of worker satisfaction using clearly articulated job expectations.¹ Chronic understaffing with required overtime and poorly constructed scheduling will turn a warm and caring health professional into a "burned out" problem. As a result, the emergency department will come to resemble a war zone, with the overworked staff appearing angry, tired and uncommitted.

To prevent such a scenario, there must be an administrative commitment to customer satisfaction predicated on assuring caregiver satisfaction, which must transcend the usual barriers that exist across functional (nursing, physician, administration) lines. It is important for all involved staff to share the view that their mission is to relieve patient suffering, anxiety and fears, while attending to their emotional needs. The role of the caregiver is greatly enhanced if the department is operated in an efficient manner, with staff assigned to specific duties within their scope of training.¹ Performance expectations should be realistic, and must be understood by all. The kind of emotional sensitivity required of the staff demands an environment responsive to problems, with an eye toward using staff input to maximize operational efficiency.

In order to identify the factors that are most important to emergency department patients and their families, Bursch et al retrospectively surveyed those who had received treatment in an attempt to identify the different variables influencing customer

satisfaction. The results showed that the total time patients spent in the ED and patient perception of their waiting time for an ED bed are not as important to patient satisfaction as receiving prompt and caring service.² They did not survey the patients who had left without treatment (LWT).

It has been shown that prolonged waiting time is a major factor responsible for patients leaving without treatment, the ultimate sign of patient dissatisfaction.³ LWTs appear to increase significantly with increased departmental census and increased admissions through the ED, both of which tend to lengthen delays.⁴ Although patients who are willing to wait for treatment will overlook the wait if care was deemed appropriate, the LWTs had no such experience to offset their impression. These patients not only represent lost revenue, but can also be a source of negative publicity and litigation against the hospital.

Too Much Information?

It is important for there to be a system in place to inform patients and family of their current status, with an explanation of any delays through the process. Patients rate their overall satisfaction higher if they receive communication from the staff at the onset and regularly throughout their ED stay.^{5,6} Patients who are given exact information at the time of arrival were more satisfied with their overall treatment than patients who received information later during their ED visit.⁵ The improved satisfaction with increased communication occurs despite the fact that patients' recall of the actual content of the communication is minimal. A study looking at parental recall after a visit to the ED showed that despite high parental satisfaction with communication, many parents cannot fully recall their child's diagnosis, treatment and instructions for follow up.⁷

Who's Complaining?

Complaints will occur in any emergency department, even if there is a strong focus on patient satisfaction. The reasons for complaints can be grouped into four major classifications: alleged inappropriate medical care, poor interpersonal skills, financial

concerns, and environmental or systems issues.⁸ Other agencies that interact with the ED, such as family, administration, paramedics and private doctors may also be the source of complaints.⁹ These complaints have much in common with patient complaints in that both often center around unrealistic expectations.

From a patient's point of view, a minor, relatively unimportant problem should be easy to take care of and therefore quickly resolved. This mindset is diametrically opposed to the emergency provider's point of view where the patients with the most serious problems are prioritized over those with less urgent complaints. In a pediatric ED, it was shown that there were 69 complaints per 10,000 visits in the nonurgent medical portion of the ED, whereas patients seen emergently (critical care and trauma) had a significantly lower complaint frequency of eight per 10,000 visits.¹⁰ Complaints are also more common with patients from higher incomes, as referenced by their home address ZIP codes.¹¹

Once a complaint has been registered, there must be a consistent process that assures that the problem identified has been investigated. Although less than 50 percent of complaints are valid after investigation,¹⁰ each must be evaluated and the complainer treated with respect.⁹ Documentation of recurrent problems can often be used in a quality program to make systems or personnel changes within the ED and hospital.

Great Expectations

There are many different approaches to be used in addressing the expectations of quick service, especially in the less-urgent population. One way is to open a less urgent area within the department to care for these patients. Establishing a "Fast Track" area for less urgent patients can be cost effective, as it can decrease the number of patients leaving before being evaluated by a physician.¹² With cost pressures rising, many of these less urgent areas are being staffed by physician's assistants and nurse practitioners. It has been shown that patients are equally satisfied with nurse practitioners in an ambulatory care setting as those seen in the usual fashion by physicians.¹³

A focus on patient satisfaction is imperative for the effective management of an emergency department. In serving as the initial point of contact with the hospital, the reputation of the emergency department can significantly influence the reputation of the hospital as a whole. Reputation becomes especially important with the inevitability of a continued move towards managed care as emergency departments with poor reputations for quality will cease to have patients. Hospitals need to have systems in place to continually monitor satisfaction trends, and to take corrective action as needed. Patients expect the four C's: convenience; caring (rapport and trust); care (quality of service); and cost.⁸ These issues need to be addressed in a proactive manner that prevents complaints before they happen.

Despite the episodic nature of emergency care, most patients express satisfaction with the care rendered.^{5,6} Emergency departments should assure that this trend continues, and thus enhance their position for continued participation in managed care. There needs to be a series of steps taken to allow implementation of an effective patient satisfaction system.

Possible Solutions

First, there needs to be an agreement between the hospital administration and the ED administration that patient satisfaction in the ED is imperative and needs to be jointly addressed. This first step may be difficult in many instances if the ED is staffed and managed by an outside organization. There needs to be an analysis of the department's current staff interactions to see if there are intradepartmental problems interfering with care. The physicians, nurses, aides and clerks need to work as an effective team with interpersonal respect and trust for there to be a basis to begin a patient satisfaction focus. There may need to be significant dialogue before this first step is accomplished.

Once the ED staff begins working as a team, there needs to be a major change in outlook. There is often a certain arrogance among emergency personnel that expresses itself in annoyance and anger towards patients

who demand service. The staff views their role as one of critical care specialist, not service providers. If unchecked, this mindset will sabotage any patient satisfaction plan, since only those patients who satisfy some arbitrary measure of severity of illness are properly treated. What staff members need to understand is that technical expertise is a given in today's high-tech medical world. The changing insurance marketplace, with more choice and increasing cost, make patients view medical care from a consumer's point of view. As consumers, they demand not only the highest quality medical care, but demand that it be delivered in a prompt and courteous manner. Patients, after all, deserve to be treated with the utmost respect. The customer service focus needs to be promoted over and over again to the staff in order for the caregivers to switch their perspective so that it meets the patient's expectations.

When complaints and compliments arrive, there needs to be a system to evaluate, document and educate the staff. Complaints should be evaluated in terms of any systems problems that may have contributed to the complaint. Searching for a responsible individual on whom to heap blame for the complaint is to be deplored. Compliments, on the other hand, need to be held up as badges of honor for responsible individuals, since the system will not change without positive reinforcement.

When a complaint arrives, there should be an immediate letter acknowledging the complaint and assuring that an investigation will take place. If possible, follow up at the conclusion of the investigation should be personal, and made over the phone so that other issues can be discussed. The analysis of trends in complaints should be incorporated into the overall department- and hospital-wide quality improvement program, and help influence decisions for future capital spending, or for new program initiatives, such as "fast track."

Conclusion

In summary, patient satisfaction in the emergency department setting is crucial for the future of the department and the hospital.

To measure and improve satisfaction, there needs to be strong, coordinated leadership which assures that each step of a patient's journey can meet or exceed expectations. A high degree of satisfaction can be marketed effectively to patients and managed care providers. The ED will then become an asset for the hospital or hospital system and help them survive the toughening marketplace for healthcare in the future.

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The Shape of Things to Come

E. Wayne Martz MD

We all know the medical care delivery system is changing, quite independent of any federal legislation. Without central direction, changes across the country are spotty, some areas faster or slower than others. The biggest and fastest changes seem to be in large groups. We in Delaware may not be in the mainstream, so might benefit from knowing what is being tried and what the experience is elsewhere.

A consulting firm from Washington, D.C., known as "The Advisory Board Company" has conducted a detailed survey of 20 innovative groups from autumn 1994 through spring 1995 and their findings were presented at Wilmington Hospital, October 11, 1995, by a dynamic and spirited young woman named Carley Falk. She only reported the findings, and carefully avoided interpreting, advising or advocating anything. Nevertheless the unpopularity of those who bear bad tidings still generated some aggressive and perhaps hostile questioning. Most would agree she did a very good job.

The study was done on 20 innovative group practices, five in the east, seven on the west coast and eight in the mid-west and Rockies. The focus of the report was on reform as a means of cost control (reduction) and dealt with five major categories of activity: 1) prevention 2) managing primary care, 3) managing specialty care, 4) hospital care, and 5) long-term care and hospice. Some savings is possible in each category, but of the total, only 2 percent can be realized from prevention.

Managing primary care can save 4 percent, and long term care can produce 7 percent of the savings. The vast bulk of the savings realized in the centers studied has come 33 percent from managing specialty care and 54 percent from managing hospital care (largely avoiding it).

Prevention

In terms of prevention, in most cases the savings is not worth the cost, especially since one is only saving the patient for more expensive care later on. The Advisory Board Company proposed six criteria which must be met for a disease or problem to be considered worth while. First, it must be important in terms of numbers. Second, there is a reliable way of recognizing it before there are symptoms. Third, the detection method is reliable and cheap. Fourth, early treatment is effective. Fifth, we have the capacity to treat it, and sixth, total costs are acceptable. Screening is usually cost effective only if targeted to a high-risk audience.

As an example of futile screening they called attention to PSA screening for prostate cancer. By age 80, 80 percent of men have nests of malignant cells in the prostate, yet only 2 percent of men died of prostatic cancer. Finding the malignant foci must necessarily lead to radical surgery or radiation therapy, both expensive, but in addition the complication rate is high (incontinence, cystitis, impotence, bleeding, infections) all with little if any effect on mortality or life expectancy. A

more suitable cost-saving measure is influenza vaccine annually, which has been clearly shown to reduce hospitalizations, morbidity and mortality in the elderly.

Another candidate, which at first glance appears unlikely, is falls and fractures. Nationwide these costs are double the cost of cardiac catheterizations. They can be reduced 26 percent (demonstrably) by patient education, muscle strengthening, gait training, and "environmental modification" (get rid of hazards, use a cane, etc.).

Primary Care

Cost savings in primary care are not great, largely because the amount currently going to primary care is not great. However, some significant savings can be realized by shifting care of some common illnesses (e.g., urinary tract infections, upper respiratory infections) to "physician extenders," such as physician assistants (PAs) and advanced practice nurses (APNs). Even greater savings can be effected by patient education and simple protocols, so patients can better care for themselves. Nurse triage and more efficient use of the telephone can also reduce costs.

Specialist Care

The opportunity for major savings really begins with management of specialist and sub-specialist practice. The first step lies in expanding the role of the primary care

physician (PCP) to carry out many activities and procedures currently done by specialists. This continues with use of PCPs as gatekeepers. Some groups use panels of generalists and/or specialists as appeal boards or primary decision makers. (Figures 1, 2, 3) Finally the single measure that has the largest effect on specialist costs is the use of capitation, which produces drastic reductions in the number of procedures performed. This is true across the board — cardiologists, dermatologists, gastroenterologists, gynecologists and every other where it has been tried and measured.

A special case is psychiatry where 2 percent of the covered population generates 80 to 90 percent of the utilization. Here a multi-pronged approach has proven more effective, at least for one mental health group. They have open access on a 24-hour-a-day basis to a team of psychiatrists, psychologists, social workers, APNs and counselors. There is rapid triage to appropriate resources, such as various types of counseling, group therapy, substance abuse treatment, community support systems. They feel delay is expensive, and their seven-day-a-week operation, 24 hours a day, has reduced the need for in-patient care to 10 to 30 percent of what it was previously.

Hospital Care

Finally, the greatest cost reduction of all lies in better control of hospital stays. We are already

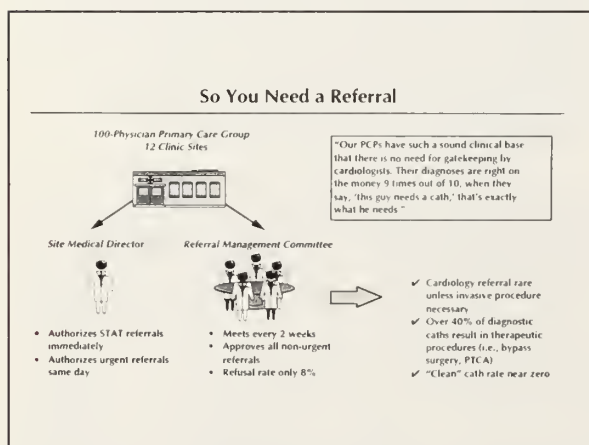


Figure 1. Source: Advisory Board interviews.

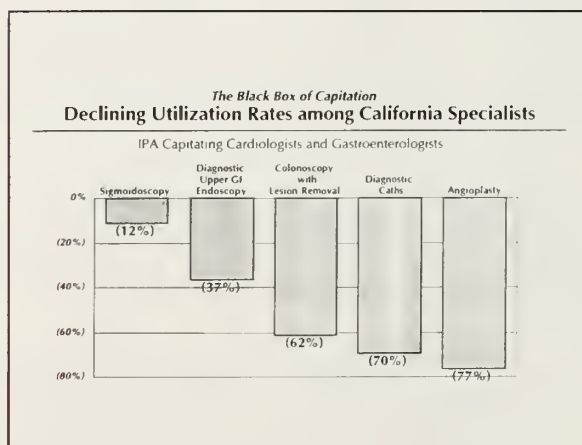


Figure 2. Source: Advisory Board interviews.

familiar with shortened hospital stays, but the other great saver of hospital days lies in efforts which avoid hospitalization entirely. Walk-in clinics or ambulatory care units which function evenings and weekends are a big help. For those who must go to the emergency department there is definitive care right there, and when indicated, prolonged observation without admission, such as for head injuries, evolving appendicitis where diagnosis is in doubt and such. Except in obvious true emergencies, admission to a hospital bed is by a committee of physicians. Some hospitals have full time salaried clinicians who handle all in-patient care. The PCP can visit of course and have important input, but definitive care is by the in-patient physician, who has access to capitated specialists and subspecialists. Other duties of the hospital clinician include rounds on all patients two, three or more times each day, expediting ICU stays, managing length of stay, preparation for discharge, and arrangement of home care or other follow-up. With these measures hospital days per 1,000 patients per year commonly drops from 450 to about 170. (See Figure 4)

Long-Term Care

The costs of long-term/chronic care are already about as low as we can achieve given legal mandates for well-trained and competent people. The hospice for those anticipating death within six months, "high acuity" skilled nursing facilities for those preparing for discharge, advance directives for the permanent invalid or bed-ridden patients. Cost is large because of volume, but opportunities for savings have not been recognized.

The report, as noted previously, was not presented in any advocacy fashion but simply as information. Clearly there are negative aspects to all of these reforms, but the need to change seems clear to nearly everyone, and Carley Falk presented some of the thinking and action in the United States at the present time.

Reporting for the reporter —

E. Wayne Martz MD

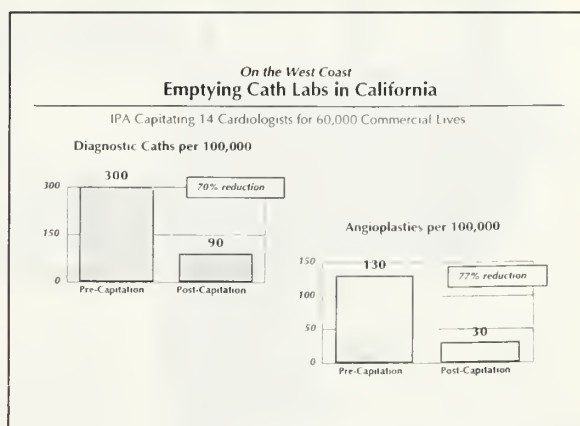


Figure 3. Source: Advisory Board interviews.

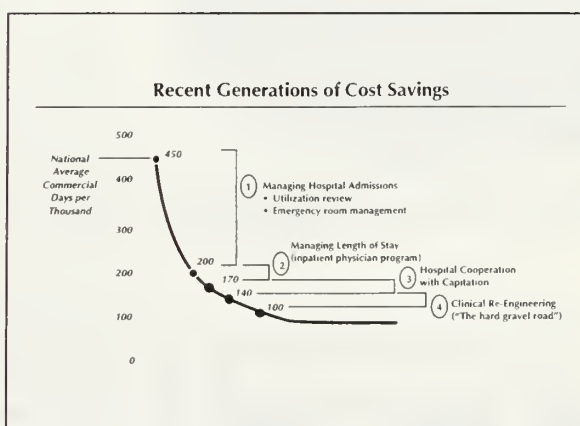


Figure 4. Source: Advisory Board interviews.

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Newly Licensed Physicians in Delaware

E. Wayne Martz MD

In the seven meetings of the Board of Medical Practice from February through August, full licenses were issued to 125 physicians which would extrapolate to 216 per year. Twelve of these 125, approximately 10 percent, were osteopathic. We have in Delaware around 2,000 licensed doctors, about 1,600 of whom are in active practice. If we postulate an average practicing life of 33 years (ages 30-63) this calculates to a 3 percent turnover per year. Of the 1600, a 3 percent loss per year would be 48 doctors, which would translate to the numbers needed each year to keep the total constant.

Of the 216 newly licensed, many will continue to live in neighboring states and open a second office in Delaware. Others will only stay a short time and leave. Still others, such as industrial medicine, research, academic faculty, and others may never become a part of our practicing community. However, as a very rough estimate, I would say we are licensing about three times our basic replacement need. It may be of some interest to know the specialty background of the 125. They are as follows:

Internal Medicine (and subspecialties)	30
Obstetric Gynecology	12
General Surgery	11
Family Practice	10
Emergency Medicine	10
Pediatrics (and subspecialties)	8
Psychiatry (and subspecialties)	7
Anesthesiology	7
Radiology (and Radiation Oncology.)	8
Ophthalmology	5
Orthopedics	4
Physical Medicine/Rehabilitation	4
Pathology	3
Dermatology	2
Otolaryngology	2

One each of Occupational Medicine and Plastic Surgery

None of Thoracic Surgery, Urology, Neurology, or Public Health/Preventive Medicine

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Is Cancer Screening Always Good for Patients?

James M. Gill MD, MPH

As a primary care physician, I find the high rates of cancer in Delaware troubling and frustrating. Despite an increasing armamentarium of treatments and diagnostic tests, little headway has been made in decreasing these rates for most cancers. One way to respond to this problem is to increase our efforts to detect cancer in its early stages through screening tests. Using physician reminder systems can help to increase the rate of cancer screening.¹⁻⁴ In the September 1995 issue of the *Delaware Medical Journal*, Dr. Chodos demonstrated one type of reminder system, the "cancer screening checklist."⁵ As with other types of reminders, such checklists have been found to increase rates of cancer screening.²

As physicians we must ask ourselves whether increased cancer screening is always a good thing. While screening will certainly increase the chance of early detection, this does not necessarily translate into a decrease in morbidity or mortality. For example, in the case of prostate cancer, there is little direct evidence that early detection and treatment is beneficial.⁶ Even when early detection has benefit for some patients, these benefits may be outweighed by the detrimental effects that screening may cause to other patients. For example, breast cancer in women under the age 40 results in a high rate of false positive results.⁷ These false positive can result in increased morbidity or mortality from breast biopsies. Unfortunately, Dr. Chodos' proposed cancer screening checklist does not distinguish between screening tests that are known to be beneficial and those that are not. For example, while he recognizes that screening for prostate cancer is not known to be beneficial, it is included in the checklist.

Dr. Gill is the research director for the Department of Family and Community Medicine, Medical Center of Delaware, Newark, Delaware.

Because cancer screening can be either beneficial or detrimental, various groups have moved toward an "evidence-based" approach to cancer screening. This means that screening tests are recommended only when there is reasonable evidence that the benefits of screening outweigh the risks. The best example of this approach is demonstrated by the U.S. Preventive Services Task Force (USPSTF),⁶ although other organizations such as the American Academy of Family Physicians and the American College of Physicians have followed their lead.

The most recent report of the USPSTF, released in November of 1995, recommends PAP smears in sexually active women up to age 65, clinical breast exams in women age 40 and up, mammography in women ages 50-70, and sigmoidoscopy or fecal occult blood testing in persons age 50 and older. Screening for prostate cancer is not recommended at any age for the general population. Also, screening the general population for most other cancers (such as cancer of the lung, ovaries, bladder, and thyroid) is not recommended. This is because for these cancers, there is no good evidence that the benefits of screening outweigh the risks.

Despite the widely publicized guidelines of the USPSTF and other organizations, many physicians persist in performing screening tests that are of no proven benefit.⁸ This is understandable to some degree, as medical schools rarely teach the concepts of evidence-based medicine, and frequently encourage the perception that "more is better." Also, physicians must contend with the possibility of patient dissatisfaction or legal ramifications that could result from not screening. There is also the time issue: it is frequently easier to order a PSA than to explain to a patient why this test is unlikely to be beneficial and is potentially harmful. However, our first

obligation as physicians is to "do no harm." We should be just as reluctant to perform screening tests that are of no proven benefit as we are to prescribe antibiotics for patients with a viral infection. This does not mean that we should give up on cancers for which we have no effective screening test. We should continue primary prevention to reduce the risk of cancers (through counseling on smoking cessation, dietary changes and other health related behaviors). We should also continue research to improve our knowledge of current screening tests and to develop new screening tests which may prove to be beneficial.

Using screening checklists and other reminder systems are an excellent way to improve the quality of care in our offices. However, these checklists should remind us to perform tests which are known to be beneficial to our patients. In order to develop such checklists, physicians can use the guidelines of the USPSTF or other organizations which employ an evidence-based approach. Using these guidelines can help to improve the health of our patients while minimizing their exposure to the costs and risks of unnecessary tests and treatments.

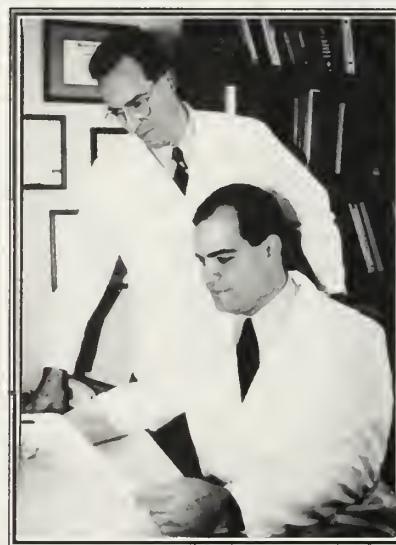
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MSD MONTHLY ACTIVITIES

Working for You: November 1995

Leadership Activities

- Several meetings were held throughout the month with members of the Delaware General Assembly to discuss the Society's legislative agenda for 1996.
- Dr. Permut was interviewed on TV Channel 12 regarding Medicare reform.
- Dr. Bradley and Mr. Meister represented MSD at the monthly meeting of the Delaware Health Care Commission.
- Mr. Meister represented MSD at a meeting of the Delaware Public Policy Institute Task Force on Welfare Reform.
- Mr. Meister attended a meeting of the Board of Medical Practice and public hearing on the practice regulations for Advance Practice Nurses.
- Drs. Bradley, Tavani, Edell and Mr. Meister met with Governor Carper and DHSS Secretary Nazario to discuss a range of issues, including HB 321 and Medicaid managed care.
- Dr. Virginia Collier and Mr. Meister met with representatives of the Delaware Academy of Medicine to discuss a state-wide telemedicine and video conferencing project.
- Mr. Meister represented the Society at a meeting of the Medicaid Medical Care Advisory Committee.
- Drs. Bradley, Howard, Maxwell, Permut and Mr. Meister met with the Executive Committee of the Association of Delaware Hospitals to discuss development of a state-wide computerized health information network and provider sponsored managed care organizations.
- Mr. Meister attended a meeting of the DHCC Certificate of Need committee.
- Mr. Meister attended a meeting of the DHCC health data committee.
- MSD Legislative Specialist, Philip Corrozi, and Mr. Meister met with Delaware Insurance Commissioner, Donna Lee Williams, to discuss the Society's legislative proposal to regulate managed care.
- Drs. Bradley, Permut and Mr. Meister met with senior BCBSO officials to discuss a range of issues including the development of a state-

wide computerized health information network and Medicaid managed care.

Physicians' Advocate Program Activities

- Presented programs in Dover and Newark on "Front Desk Procedures" Topics discussed included: enhancing "people skills" to maximize patient satisfaction, asking for - and receiving - payment at the time of service, and teamwork. Over 100 staff members attended.
- Consulting for two medical practices regarding practice evaluation and practice management issues. Also held inservice for a medical practice regarding front desk procedures. Aided several practices in their search for new employees.
- Attended MSD annual meeting and staffed the MSD display board. Answered physicians' questions regarding: Delaware Physicians Advocacy Program, the contract review service, the upcoming MSD member benefit — credentialing.
- Held inservice for the Medical Center of Delaware's Medical Education Program "Being in Charge vs. Being in Debt." Topics discussed included: helpful hints on setting up or joining a practice, understanding managed care, keeping on top of the changing medical marketplace and planning for the future.
- Answered various inquiries from physicians and staff regarding Medicaid/Managed Care, silent PPOs, deselection from an insurance panel and guidelines for choosing a collection agency.

Continuing Medical Education Activities

- Sponsored 28 educational activities for Category 1 credit.

Major Meetings

- Environmental & Public Health Committee
- APN Regulations Meeting
- Physicians' Health Committee Meeting
- MSD Annual Meeting
- Medical Care Advisory Committee Meeting
- DSCC Task Force Meeting



Over 250 physicians gathered in Wilmington on November 17 and 18, 1995, to discuss and celebrate medicine in Delaware at the Medical Society of Delaware's 206th Annual Meeting. History was made as Past President Michael J. Bradley DO, installed Carol A. Tavani MD, as the first woman president in the history of the Medical Society.

Delegates assembled on Friday, November 17 for the House of Delegates meeting. Speaker Roger B. Thomas MD, presided over the House which acted on a number of resolutions including reaffirmation of unified membership of the Medical Society and the AMA, reaffirmation of existing policy of managed care, Medicare conversion factors, as well as resolutions honoring I. Favel Chavin MD, Leonard P. Lang MD, and the MSDIS Board of Directors.

The scientific session, held on Saturday, November 18, presented talks on a wide range of topics including: teenage pregnancy, advances in cancer gene therapy,



Michael J. Bradley DO places the president's medal on Carol A. Tavani MD.

management of stroke, detection and evaluation of osteoporosis, and the risks and benefits of hormone replacement therapy.

The highlights of the House of Delegates and the Annual Meeting are featured here in a two part series to appear in this and next month's issues of the *Journal*. ■



Proceedings of the House of Delegates, 1995

Part I

The 206th Annual Meeting of the House of Delegates of the Medical Society of Delaware was called to order at the Delaware Academy of Medicine Building, Wilmington, Delaware, on Friday, November 17, 1995, at 1:30 p.m. by Michael J. Bradley DO, President, Medical Society of Delaware.

A quorum was declared.

A motion was made, seconded, and approved to adopt the Proceedings of the 1994 session.

The session included remarks by Palma Formica MD, a member of the Board of Trustees of the American Medical Society; recognition of other special guests and past presidents of the Medical Society of Delaware who were present; reports of the Reference Committees; Dr. Bradley's address as President of the Medical Society of Delaware; and the report of the Nominating Committee.

Dr. Bradley called upon Roger B. Thomas Jr., MD, Speaker of the House of Delegates, to preside during the reports of the Reference Committees.

Report of the President

Reports of the Officers

Report of the President

This past year has been a year to remember both for the

Medical Society and for me. The Society is clearly moving ahead on many issues and projects for the good of the Society and our patients. We are a force which has commanded the respect of insurance carriers, state and federal elected officials and the media. You can be proud to say you are a member of the Medical Society of Delaware.

I would like to highlight the year's most important issues and ongoing projects.

Our legislative agenda has been as full as any year that I can remember. As I reported at other times, our PPA II, HB 321, Relating to Fairness and Choice under Health Benefits Plans, is moving through the Labor Committee. It has the recommendation of the Commissioner of the Insurance Department behind it. Along with a companion bill from the Insurance Commissioner, it will level the playing field for the managed care industry in Delaware. Patients will be informed about the plan before they are enrolled, plans that are restricted in their physician panel must have an off-panel benefit, and all physicians will have the right to apply for credentialing and must be told of the reasons for non-selection. Any physician being dropped from a plan

must have due process along the way. The bill is not an any willing provider act.

The Voluntary Initiative Program to expand referral services to the uninsured in return for free care (VIP II) is at risk of never getting off the ground. Our previous Governor promised to support our Bill, HB 124. This would free physicians and nurses who treat the uninsured for free from simple malpractice suits. Our attempts to get this past the trial lawyers' association are meeting with formidable opposition. Even with the support of the Delaware Health Care Commission, we had to lay the bill down on the table last June. We will be bringing it out again in January for another attempt. All we are trying to do is to give away free medical care to those who are unable to afford insurance but are too well off to be on Medicaid. Unless this bill is passed, the VIP program will sunset, since all Medicaid patients will have physicians.

Other bills include HB 340, to provide parity between medical and psychiatric services; SB 72, a new advance directives bill which includes a surrogacy hierarchy; and HB 259, a bill to place the prescriptive powers of optometrists under the Board of Medical Practice. This bill is part of an attempt to place all non-physicians who are practicing medicine under the Board of Medical Practice for their final review and observation.

As part of the Joint Sunset Review of the Board of Medical Practice, the MSD has written

a new definition of surgery. Again, this would limit any new surgical procedures to final review by the Board before any non-physician provider would be allowed to be credentialed. Nothing in this bill would limit the procedures for which any licensed provider is now credentialed.

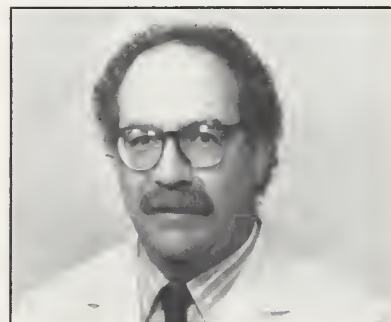
The Delaware Health Care Commission spent over six months looking at the cost of malpractice insurance on health care in Delaware. Their support of the VIP II Bill, HB 124, was accompanied by the recommendation that there be a cap of \$250,000 on non-economic damages in any malpractice case. As of the end of June, the DHCC had not found a sponsor for that bill.

On the federal level, the House and Senate have yet to come to compromise over the product liability legislation. In the House version there are several physician-friendly amendments, including the \$250,000 cap. The Senate version is pure product liability, with Senator Dole promising to bring back medical liability as a separate bill. Only time will tell if that occurs in this near election year.

After two years of being a charter sponsor of the Health Care Providers Association of Delaware, the MSD has severed its ties with that group. At its inception, there was the feeling that HCPAD might be influential at the state and national level with the new emerging health systems, but that failed to occur. Left with no mission and a group too

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Michael J. Bradley DO, was the first osteopathic president of the Medical Society of Delaware.



Reference Committee A was chaired by Leo W. Rasis MD.

diverse to achieve consensus on many issues, it was felt to be a liability for us to continue.

And lastly, on the legislative front, I would like to thank all of our members who have joined DELPAC and to urge those who have not to reconsider. Until the Political Action Committees are outlawed, they are the one and only way for the society to present a unified voice to the legislators. Of course, we encourage you to donate some of your free time in a similar way, but we think you would benefit more from the small price of DELPAC membership dues.

One of this year's successes has been the merger of the Medical Society of Delaware Insurance Services with Zutz/PLI. This merger has brought over 60 percent of the physicians' malpractice insurance under one broker. The success of this project has been such that the dividends brought to the MSD will be nearly \$200,000 this year. This phenomenal growth might allow the MSD to reduce its dues, now the 48th lowest in the county, even lower. We will still provide any and all insurance a physician at work or at home needs. Our thanks go to the joint venture committee members: Tony Cucuzzella, Bill Duncan, Steve Grubbs, Joe Lieberman, Wayne Martz, Mark Meister, and Greg Pahnke. In a separate parallel venture, MSDIS has provided numerous health insurance products through the Health Select Program. This program is generating commissions approaching \$14,000 per month and is growing.

I touched on the effects of managed care many times this year, and it seems that it truly is the year of managed care. Of great importance to the citizens of Delaware is the introduction of managed Medicaid program. Beginning January 1996, nearly 7,300 new Medicaid patients will be covered in the expanded program. We have been informed that Principal Healthcare/Mercy Medical System and Amerihealth have been given statewide contracts while BCBS Delaware will be in Kent and Sussex and First State Health will operate in New Castle only. The health benefits manager selected is EDS. Throughout this project, the MSD has tried to stay involved with the process, advising the Secretary of Health and Human Services and others in the administration. However, we are seeing some major problems occurring already. Because the process was compressed into a few short weeks, the insurance companies have been unable to fairly market their products to the physicians properly. This has led them to assume that the physicians of Delaware will blindly sign up with them out of good faith without being able to negotiate a contract or even see a fee schedule. We are no longer the pushovers we once were. Our MSD and its *Physicians' Advocate* have worked hard to carry this message to the insurers and the administration.

This leads me into a discussion of the expansion of the *Physicians' Advocate* Program. This capable program,

which is run by Jana Siwek, provides an ever-expanding number of services and programs to practicing physicians and their office staff. Jana Siwek writes a monthly column in the newsletter to keep us up-to-date on what's out there affecting our practices. The Contract Review Service has now completed review on the First State Health Plan, US Healthcare and Amerihealth, with three more contracts to come in the next six months. Those of us who have joined this service have received at least triple the small investment already. Workshops throughout the year included accounts receivable, legal aspects of hiring and firing, malpractice info for office staff, managed care contracting, delinquent accounts, human resources, and front desk problems. Special alerts were sent out on topics such as the spread of silent PPOs. An excellent EDI Expo was held this April to introduce those of us computer illiterates to the advantages and pitfalls of Electronic Data Interchange. An office networking group has been set up in New Castle County, and a second is just forming for Kent and Sussex. These meetings of office managers allow free interchange of ideas and problems common to all. One of the first benefits of this will be a confidential review of office staff salaries. The Capitation Strategies Workshop and seminar was sold out, expanded and sold out again. These and many other day-to-day activities of our *Physicians' Advocate* have proven the worth of the

program. As of October 1, the *Physicians' Advocate* has become a full-time position, and soon I would see a need for more staff if this program grows into a full service management services organization (MSO).

Another key function of the MSD is physician advocacy. The leadership of the MSD meets with many members of the insurance industry and our government leaders to advocate for your rights and those of your patients. We meet regularly with BCBS Delaware, AETNA/DuPont, AETNA/Chamber of Commerce, Pennsylvania Blue Shield (Medicare Carrier), A.I. DuPont Institute and others to ensure that these carriers are aware of the impact on Delaware Physicians of their programs. We have an excellent relationship with these carriers and are taken as a serious force to be reckoned with.

Two formal meetings were held with Governor Carper during which we discussed the role of the Board of Medical Practice and the need for a Physician Medical Director, the VIP II program and our accompanying HB 124, and malpractice reforms including the cap on non-economic damages. We hope to be able to sway the Governor into more vocal support of some of our initiatives.

This year the Delaware Health Care Commission received new leadership in the chair as Ed Bennett took over. His mission has been to get the commission back on track for health care reforms in Dela-



Reference Committee B was chaired by Harry A. Lehman III, MD.



Joseph F. Rubacky III, MD chaired Reference Committee C in the library at the Delaware Academy of Medicine.

ware. The Cost Containment of the DHCC proposed two recommendations which the full commission backed. These were the \$250,000 Cap and support of VIP II. I have begun serving on the Primary Care Committee of the DHCC as it reviews the needs of Delaware in the primary care areas and also reviews the DIMER program. I will be happy to continue on this committee next year and until the report is finished. I feel the DHCC is in support of incremental changes in the health system compatible with our goals.

We had a very productive meeting with Secretary Vincent Meconi and Carol Ellis regarding the future of the Board of Medical Practice. After several years, Wayne Martz has resigned and the Board came under the Sunset Committee Review. Secretary Meconi reassured us that a physician will be hired as a part-time Medical Director. This will allow our Physicians' Health Committee to continue to report physician-to-physician on the many cases it handles. The Sunset Committee has favored our writing of an expanded definition of surgery, and the roles the Board of Medical Practice would have in the oversight of any non-physicians who wish to have surgical privileges.

A meeting with the Delaware State Osteopathic Medical Society was held to see if the two organizations had some common community or political issues to cooperate on. We found our views to be in alignment, with no areas of disagreement. However, many

of the DSOMS' members have dual MSD membership, and our programs fulfill many of the DSOMS' Leadership goals. Their organization does not have the number of members to be a viable political ally. We will continue to keep them informed of matters important to all Delaware physicians.

Lastly, the News Journal was very responsive to our meeting with them, at which time we discussed the PPA II and VIP II. They were so much in our favor that two of the editors were fighting between themselves rather than with us.

The Volunteer Initiative Program (VIP) has had another successful year. Since its inception, the MSD has placed over 4,000 Medicaid patients with private physicians. These patients now have medical homes, and a study by Dr. Gill at the Medical Center has shown that the VIP Program has had a significant impact on reducing inappropriate visits by Medicaid patients. This innovative program will sunset next year with the start of Diamond State Health Plan, the state's new managed care program. All current Medicaid patients, except those in long-term care and some special programs, will be mainstreamed into current or new HMOs. We have been working with the Secretary of Health and Social Services to protect the patients and physicians from arbitrary selection and enrollment problems that have occurred elsewhere. The *Physicians' Advocate Program* has placed notices in our monthly newsletters for several months

informing the members of the upcoming changes, and Jana Siwek is more than willing to help with any problems you are encountering. A campaign this year netted \$200,000 for the VIP Foundation. We are thankful for the donations of the Longwood Foundation, Crystal Trust, Dillon Fund and others. These monies will allow us to fund the ongoing work of the VIP for another two years. However, unless HB 124 is passed, there will be little new work for the VIP. Please work with us to see that the VIP does not sunset.

The leadership opportunities these past three years have been very numerous. This year alone I have represented the MSD at the interim and annual AMA meetings, the national leadership conference in Washington, the annual meetings of New Jersey and Pennsylvania Medical Societies, and the Delaware State Dental Society. Our AMA delegates and alternates have been very active, and the two resolutions we took from our annual meeting last year were passed on to the Board of Trustees of the AMA for review. Our recommendations for a point of service option in the PPA II were incorporated into the final act. Last year we decided to fund our alternate delegates to attend the AMA annual meeting, and this proved to be an excellent idea. I would like to recommend that the Board of Trustees consider funding for the alternates for interim meetings if we continue to be financially sound. Steve Permut continues to participate in the study

of the federation, with the final report to come out at next month's interim AMA meeting in Washington, D.C. Whenever possible, I have participated in news conferences, town meetings, panel discussions, I have given testimony to the Delaware Legislature and the Delaware Health Care Commission espousing the goals of our society and the needs of our patients. We have had an excellent relationship with our Congressional representatives and their staffs and are called upon for our advice on health care matters. Other members of the Executive Committee including Carol Tavani, Tom Maxwell, Paul Howard, Martin Begley, and Tony Cucuzzella have represented the MSD throughout the area in my absence.

We have begun to tackle the problem of where to lead the MSD into the next century. Under the direction of the Long Range Planning Committee, the MSD has decided to form a Management Services Organization. Our Executive Director is in the process of coming up with a business plan, cost estimates and a time line for this project. One of the first programs will probably be a credentialing service for members to assist them with HMOs and hospital privileges. The NCQA has several pilot projects with state organizations doing such work now. The ability to have a centralized confidential credentialing bureau will make all of our lives easier. Beginning last January, the LRPC and the Executive Committee have held meetings on the role

"The influence the MSD has is considerable and has been growing for several years."

Michael J. Bradley DO
MSD President 1995-1996



Palma E. Formica MD brought greetings from the AMA to the MSD House of Delegates.

of the Society in the current health system reform atmosphere and concluded there is a need for a more active MSD organization. In addition to the MSO formation, we will continue to evaluate the proposal of First Options. This physician and hospital HMO started in New Jersey and is planning to become a regional HMO. While its goals and progress to date have been attractive, we will be very diligent in evaluating whether the MSD should endorse this concept.

I would like to briefly discuss the ongoing projects of the Society. The Delaware Medical Education Foundation has formalized the funding of the Physicians' Health Committee for the foreseeable future. Donations and membership fees paid to the Foundation can now be directed to a separate endowment fund. As this fund grows, we hope to be able to pursue some community education and/or service programs. Please consider becoming a member and donating to the fund next year. As I mentioned earlier, PNC Bank is the executor of the Dillon Fund. This fund has the potential to significantly benefit the MSD. We currently are named to advise PNC on distributions of the fund for medically-related projects. We are presently working on a long-term plan for this fund.

A Managed Care Roundtable Forum has begun bringing the major insurer groups together to discuss common problems. Most have given us initial approval of the concept of a credentialing service. Other items to be discussed are

common office billing and referral procedures, office record reviews and quality assurance. We feel this could be incorporated into our MSO. We have been working with one of the prominent insurers to provide the leadership and guidance for a true Community Health Information Network. Our goal would be a partnership of the MSD, hospitals, insurers and the state to form a non-profit organization not controlled or owned by any of the mentioned groups. Only through such a separate organization would we feel comfortable enough to entrust the information needed to make this project work.

In the very near future you may be able to link up with the Internet through the MSD home page. This new service will be priced below any other now available to you and could someday allow us to communicate MSD business, CME, journal articles and other services online. Along this same path, the MSD has looked into the ability to tie the state together into a teleconferencing network. This may be a joint venture with the hospitals, colleges, universities, and businesses.

Steve Grubbs has taken on the project of forming a young physicians' section of the MSD. Those physicians under age 40 or in their first five years after residency would be able to join. The YPS would have a representative on the Board, as we now have for the residency section. We wish Steve a successful project.

As this year ends, we have been caught up in the politics of Medicare reform and the possible reductions in Medicaid if states are given block grants. The Congress has been working hard to reform and transform the Medicare program to prevent it from "going broke" early in the next century. The Republican leadership began meetings earlier this year with the various special interest groups, including the AMA, on ways to save the Medicare programs. As I write this report, Congress may soon vote on the future of the program. While the AMA has had to compromise over parts of the proposal, so has every other special group. I hope the final bill will contain the many physician-friendly items the AMA has fought for. These include: malpractice reform, a \$250,000 cap on non-economic damages, relief from CLIA and Stark, anti-trust reform to allow physicians to effectively bargain, provision for provider-sponsored networks which would allow us to bypass insurance companies' involvement altogether, and a single conversion factor for RBRVS no lower than the current factor. Slowing the growth of Medicare will need the cooperation of our patients to make choices of health plans and bear some responsibility for where and how their premium dollars are spent. If reimbursements are cut further below current levels and none of the physician-friendly items are enacted, then I can see the overall outlook for Medicare patients worsening. At the present, reimburse-

ment barely covers overhead cost for many of us. Access for Medicare patients will worsen as physicians accelerate closing their practices to this group.

I would like to say again how enjoyable this year has been. The challenges we face are exciting. The influence the MSD has is considerable and has been growing for several years. Your support of the Society and myself is very much appreciated. I would like to thank the entire staff of the MSD for their help. The year would have been impossible without the help of Mark Meister, Executive Director; Beverly Dieffenbach, Associate Executive Director; Jana Siwek, Director of the *Physicians' Advocate Program*; Mary LaJudice, Administrative Assistant; Jean Gayle, Finance Coordinator; Heidi Norman, Assistant Editor of the *Delaware Medical Journal* and CME Coordinator; Laurel Haring, Editor of the *MSDNews*; Lauryn Harkness, Legislative and Community Affairs Assistant; Cindy Wright, Membership Coordinator; Kathy Fogelgren, VIP Nurse Coordinator; and Julie Bodenstab, Physicians' Advocate Assistant.

I wish Carol Tavani and the rest of the officers another successful year, and I pledge to continue working for the MSD in the years to come.

Michael J. Bradley DO
President

The report was filed with commendation for Dr. Michael J. Bradley's out-



Members of the House of Delegates listen and take notes on the proceedings.

Report of the President-Elect

standing efforts and support during the past year.

Report of the President-Elect

The past year has been a busy and productive one for the leadership of the Medical Society. Your officers have been active on the local, regional and national levels in working with insurance carriers, political forces, including visits in Washington, D.C. with our senators and congressman, and representing the Society at the annual and other meetings of neighboring state medical societies, as well as the annual and interim meetings of the AMA, where I represented the Medical Society as an alternate delegate. The officers, in addition, represent the Society at various community functions, and our presence therein has been a strong one.

I have striven to assist Dr. Bradley in his year as President and look forward to serving the Society as President in the year ahead.

Carol A. Tavani MD
President-Elect

The report was filed.

Vice President's Report

I had the pleasure of representing the Medical Society of Delaware at the Annual Leadership Conference conducted by the Pennsylvania Medical Society in May. The title of the conference this year, appropriate to the changes presently occurring at a somewhat break-neck pace, was "Coping with

Kaleidoscopic Change." There were many good speakers. The recurring themes at that and other conferences have now become familiar to us all. The Medical Society of Delaware is making great efforts to assist its members in keeping pace with these changes as they occur. We will, as a Society, need to continue in this line, and we also will need to continue to strive for a broader involvement of our membership at large. I would encourage all delegates to, in turn, encourage their colleagues to become involved with Medical Society activities.

Paul E. Howard MD
Vice President

The report was filed.

Report of the Secretary

The Society's Board of Trustees has held 10 meetings during the past year. All business transacted by the Society has been recorded in the minutes as presented by the Secretary. The Medical Society's committees and subsidiary organizations have also held numerous meetings throughout the year, and minutes are on file in the office of the Society.

A comparison of the Society's membership in 1995 and 1994 follows.

A complete report of the Proceedings of the 1995 House of Delegates will appear in the January 1996 and February 1996 issues of the *Delaware Medical Journal*. The report will also be on file in the office of the Medical Society.

Vice President's Report

Report of the Secretary

1995 Membership*

	<u>Dues:</u>	<u>Dues:</u>	<u>Aff:</u>	<u>Total</u>
	<u>Paying</u>	<u>Exempt</u>	<u>late</u>	
Kent	102	21	2	125
New Castle	724	190	107	1021
Sussex	<u>149</u>	<u>35</u>	<u>4</u>	<u>188</u>
	975	246	113	1,334

*As of 10/30/95. Figures do not include 11 pending applications.

1994 Membership**

	<u>Dues:</u>	<u>Dues:</u>	<u>Aff:</u>	<u>Total</u>
	<u>Paying</u>	<u>Exempt</u>	<u>late</u>	
Kent	97	19	3	119
New Castle	717	184	73	974
Sussex	<u>144</u>	<u>30</u>	<u>3</u>	<u>177</u>
	958	233	79	1,270

**As of 11/1/94. Figures did not include 74 pending applications.

Martin G. Begley MD
Secretary

The report was filed.**Treasurer's Report**

The financial statement accompanying this report reflects the first nine months of activity for the 1995 fiscal year. After nine months of operation, it appears as though fiscal year 1995 was below and very close to our initial budget projections with a surplus of approximately \$11,000. The following budget line items are worthy of special note:

Revenue

1. Membership dues collected for 1995 are 97 percent of budget. Thirteen physicians elected not to renew their Society membership for 1995.
2. Two dividends were declared by MSDIS Board of Directors during 1994 which are recorded as revenue for 1995. These totalled \$110,000. In addition, \$20,000 was con-

tributed to the Delaware Medical Education Foundation, which was transferred to the Society by the Foundation to help defray the Society's cost of operating the continuing medical education and Physicians' Health programs. Also during 1995, MSDIS assisted the Society by funding various *Physicians' Advocate* Programs and funded the printing of the Society Bylaws in the September issue of the *Delaware Medical Journal*.

3. Revenue generated by the Physicians' Advocate Program has exceeded budget by almost threefold for the nine months ending September 30, 1995. Response from the membership to the consulting, managed care contract reviews and office staff workshops available through the Physicians' Advocate has been outstanding.

4. Advertising revenue for the *Journal* took an unexpected but temporary downturn during mid-1995. *Journal* editor, E. Wayne Martz MD, is investigating various ways to enhance revenue and, possibly, more efficiently handle the publishing of the *Journal*.

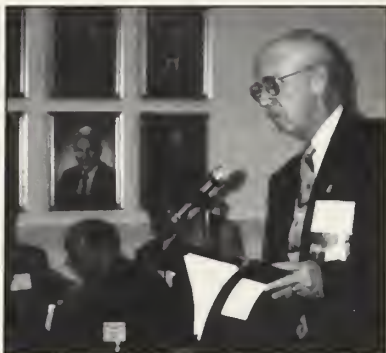
Expenses

1. Personnel for the Administrative Cost Center is slightly over budget due to the booking of the 1994 Pension Contribution (\$25,707) and Pension Administration fees (\$1,500) during August. Overall, personnel is under budget due to reductions in other departments.

2. Legal counsel expenditures are unexpectedly high this year due to several major

Treasurer's Report

Stephen R. Permut MD raises a question regarding a resolution.



James P. Marvel Jr., MD made comments about a resolution.

Kent County Medical Society

issues regarding antitrust, managed care contracts, workers' compensation issues, etc.

3. The equipment expenditures will be slightly over budget by year's end due to the need to replace a faulty hard drive on the file server of the Society computer system. Also, a review of various proposals for providing computer support services was completed, which should result in future savings in this category.

4. Dues/Contributions includes the following unbudgeted items: LPGA (\$1,000); AMA Study of the Federation (\$1,200); and University and Whist Club (\$233).

5. Miscellaneous includes \$900 for MSD lapel pins for the Board members and past presidents.

Included with this report is a statement for the Banking and Fund Account balances as of September 30, 1995. The asset appreciation has been excellent and Chip Cruise at Greenville and Jim Kalill Sr., at Compuval are to be commended for their superb fund management. Please refer to the report of the Budget and Finance Committee for more information on these investment accounts.

Many thanks and appreciation go to all of the staff, especially Mr. Mark Meister and Ms. Jean Gayle for their help in daily operations, as well as compilation of the figures and data that were necessary during the year.

Garth A. Koniver MD
Treasurer

The report, which includes

accompanying documents (1995 Treasurer's Report as of September 30, 1994; Independent Auditors' Report and Medical Society of Delaware and Subsidiary Consolidating Balance Sheet, December 31, 1994), was filed.

Kent County Medical Society

The year 1995 has been exciting for the Kent County Medical Society. Our own Michael J. Bradley DO, has served as president of the Medical Society of Delaware. He has presided over one of the most tumultuous years that organized medicine has ever seen.

In addition, another member from our county, Martin Begley MD, has served as secretary for the Medical Society of Delaware. We are proud that more and more members from Kent County are becoming active in the state society.

As of the date of this report, we have added five new members this year. In addition, two new members are awaiting election at our November county meeting.

Election of Officers: At our November 1995 meeting, a new slate of officers will be presented who will, if elected, take office January 1, 1996. The nominees are: Donald Doran DO, for president; Brian Walsh DO, for vice president; Gertrude Findley-Christian MD, for secretary. We are awaiting a nominee for treasurer. In the meantime, it is assumed that Dr. Findley-

MEDICAL SOCIETY OF DELAWARE AND SUBSIDIARY

CONSOLIDATING BALANCE SHEET
December 31, 1994

	Medical Society of Delaware Current Funds				Subsidiary * Medical Society of Delaware Insurance Services, Inc	Elimination Entries	Consolidated Balances
	Unrestricted	Delaware Medical Journal	Restricted	Custodian Fund			
ASSETS	Operating						
CURRENT ASSETS							
Cash	\$ 208,576	\$ 15,211	\$ 310,476	\$ 250,593	\$ 42,832	\$...	\$ 517,212
Investments, at cost	235,737	...	...	...	...	...	546,213
Receivables:							
Commissions	...	...	...	...	70,695	...	70,695
Dividends	40,000	...	...	...	...	...	40,000
Interest	1,652	...	...	...	...	...	1,652
Affiliates	17,311	...	7,515	...	...	...	1,206
Other	16,389	13,272	...	181,784	254	...	211,689
Prepayments	4,505	...	...	...	27,070	...	31,575
Investment in subsidiaries	100	...	...	...	...	(100)	...
	524,270	28,483	317,991	432,377	140,851	(23,720)	1,420,252
PROPERTY AND EQUIPMENT AT COST							
Leasehold improvements	20,823	27,582	...	...	48,097	...	20,823
Furniture, fixtures and equipment	82,530	27,582	...	...	48,097	...	158,209
	103,353	27,582	...	...	48,097	...	179,032
Less: Accumulated depreciation	67,526	21,114	...	...	26,514	...	115,154
	35,827	6,468	...	...	21,583	...	63,878
OTHER ASSETS							
Security deposit	300	...	...	...	...	...	300
TOTAL ASSETS	\$ 560,397	\$ 34,951	\$ 317,991	\$ 432,377	\$ 162,434	\$ (23,720)	\$1,484,420
LIABILITIES AND FUND EQUITY							
CURRENT LIABILITIES							
Dues payable	\$ 86,543	\$ 16,105	\$ 317,991	\$ 432,377	\$ 162,434	\$ (23,720)	\$ 86,543
Due to affiliated agencies	7,515	...	...	...	...	...	429,712
Premiums payable	...	2,383	...	...	6,840	...	52,371
Accrued expenses	43,148	...	...	...	70,000	...	70,000
Dividends payable	...	...	...	...	2,665	...	2,665
Amounts held for physician emeritus	32,313	...	...	...	...	...	32,313
Compensated absences payable	169,519	18,488	...	432,377	76,840	(23,620)	673,604
	58,149	2,100	180	...	...	...	60,429
	227,668	20,588	180	432,377	76,840	(23,620)	734,033
DEFERRED REVENUE							
Total liabilities and deferrals							
FUND EQUITY							
Fund balances	332,729	14,363	317,811	...	...	...	664,903
Common stock	...	...	...	...	...	(100)	85,494
Retained earnings	332,729	14,363	317,811	...	...	(100)	750,397
TOTAL LIABILITIES AND FUND EQUITY	\$ 560,397	\$ 34,951	\$ 317,991	\$ 432,377	\$ 162,434	\$ (23,720)	\$1,484,420

Fiscal Year Ends September 30.

*Fiscal Year Ends September 30.

Medical Society of Delaware & Subsidiary Consolidating Balance Sheet, September 19, 1995

BANKING, INVESTMENT AND FUND
ACCOUNT BALANCES
AS OF SEPTEMBER 30, 1995

CASH	
CASH IN BANK	\$1,087.66
PETTY CASH	96.85

TOTAL CASH	\$1,184.51
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SHORT TERM INVESTMENTS	
GENERAL FUND	\$157,735.68
OPERATING ACCOUNT	0.00
GEN FUND DE MED JOURNAL	17,290.69

TOTAL S.T. INVESTMENTS	\$175,026.37
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LONG TERM INVESTMENTS	
COMPUVAL (PORTFOLIO)	\$129,363.66
GREENVILLE (PORTFOLIO)	94,952.38
GREENVILLE-BUILDING	358,895.48
GREENVILLE-BENEVOLENCE	54,378.45
GREENVILLE-MED BENEFITS	26,715.69

TOTAL L.T. INVESTMENTS	\$664,305.66
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FUND ACCOUNT BALANCES
AS OF SEPTEMBER 30, 1995

PRINCIPAL HEALTH CARE	\$2,201.83
-----------------------	------------

FOUNDATION ACCOUNT BALANCES
AS OF SEPTEMBER 30, 1995

DELAWARE MEDICAL EDUCATION FOUNDATION	\$8,266.37
DELAWARE FOUNDATION FOR MEDICAL SERVICES	\$182,174.43

Banking, Investment and Fund Account Balances as of September 30, 1995



James R. Zdzimal, CPA†
 Vincent S. Barbone, CPA*
 Edward A. Camarota, CPA*†

HAGGERTY & HAGGERTY, P.A.
 CERTIFIED PUBLIC ACCOUNTANTS

American Institute of CPA
 Pennsylvania Institute of CPA*
 Delaware Society of CPA*
 Private Companies Practice Section

Independent Auditors' Report

Board of Directors
Medical Society of Delaware & Subsidiary
 Wilmington, Delaware

We have audited the accompanying consolidated balance sheet of the Medical Society of Delaware & Subsidiary (a not-for-profit organization) as of December 31, 1994, and the related consolidated statements of revenue and expenses, of changes in fund equity, and of changes in financial position for the year then ended. These financial statements are the responsibility of the Society's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Medical Society of Delaware & Subsidiary as of December 31, 1994, and the results of its operations and its changes in financial position for the year then ended in conformity with generally accepted accounting principles.

Our audit has been made primarily for the purpose of forming the opinion stated in the preceding paragraph. The additional information contained in this report is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated, in all material respects, in relation to the financial statements taken as a whole.

Haggerty Haggerty
 Certified Public Accountants

February 3, 1995
 Wilmington, Delaware

503 Carr Road • Suite 1-A • Wilmington, DE 19809 • Phone (302) 762-6380 • Fax (302) 762-2081

Independent Auditor's Report

Christian will continue to fill that role. The nominees for trustees from Kent County are: Joseph F. Rubacky III, DO, Donald Doran DO, and Brian Walsh DO

Quarterly Meetings: We have had four quarterly meetings and all have been well attended.

- February: Rafael Zaragoza MD, was the featured speaker. He spoke about mission work in the Philippines. I think this speech inspired many physicians.

- May: We had an excellent panel discussion on the current status of Medicare fraud and abuse. The panel included: James Sheehan, Chief, Civil Division, U.S. Attorney's Office; Gregory Sleet, U.S. Attorney for Delaware; Richard Andrews, Chief, Criminal Division, U.S. Attorney for Delaware; Gregory Miller and Mark Respanti, both of Miller, Alfano and Respanti, a law firm in Wilmington.

- August: Our crab feast at Sambo's Tavern was extremely well attended.

- November: The November meeting is planned for the week before the annual state meeting. Martin Begley MD will be featured speaker and will be speaking on how to become involved in the politics of health care reform.

Successes:

- *Physicians' Advocate* Program: One of the biggest successes in Kent County over the past year has been the *Physicians' Advocate* Program with Jana Siwek. She has been extremely helpful to multiple

numbers of the county in interceding on our behalf with various insurers. In addition, her programs to educate our office staff have been very helpful and well attended.

- Contract Review Service: The contract review service which began this year has been exceptionally helpful to all members and looks as if it is going to be even more successful in future years.

- Primary Care Physicians: The search for primary care physicians continues to be a major issue in Kent County, but it appears that with the help of Kent General Hospital, several new physicians have joined and more will be joining in the future.

Finally, I wish to thank all the members of the county who have participated in a multitude of standing and ad hoc committees for their hard work.

Joseph F. Rubacky III DO
President

The report was filed.

**New Castle County
Medical Society**

The New Castle County Medical Society held three regular membership meetings, and a joint meeting with the Delaware Society of Internal Medicine and the Delaware Academy of Family Physicians. Topics included a special presentation on Delaware physicians who served during World War II, MSDIS insurance services, an update on legislative issues, and a discussion on health care fraud.

William H. Duncan MD,

**New Castle County
Medical Society**

retired physician and Lieutenant General of the Delaware Army National Guard, presented a special program on Delaware physicians who served in the Armed Services during World War II. Dr. Duncan was dressed in a vintage World War II Captain's uniform and presented a brief history of several Delaware physicians' service, including rare photographs. He also prepared a display of the decorations, awards, honors and badges received by Delaware physicians during World War II.

William H. Duncan MD, President, Medical Society of Delaware Insurance Services (MSDIS), reviewed services available and announced a new line of products. MSDIS has been providing insurance to the medical community for over a decade. This includes Malpractice Insurance, Workers' Compensation, Liability, Disability, and Life Insurance. The new line of health insurance products is called Health Select. Health Select offers traditional indemnity plans, managed care plans, a Medicare Supplement, plus prescription drug and dental coverage options.

Philip J. Corrozi, legislative specialist for the Medical Society of Delaware, presented an update on the activities of the General Assembly. Some key issues discussed this past session included the budget bill, welfare reform, new directions in schools, corrections and the Port of Wilmington. He told the membership how to effectively contact their legislators.

The first alternative is to call and talk to the legislator directly. The second option is to write a personal letter; do not send form letters. It is important to be short, concise and to the point in your conversation or correspondence with them. He also gave the members some insight on the behind the scene negotiations and compromises which go into getting legislation passed by the General Assembly.

A panel discussion on Health Care Fraud by the U.S. Attorney's office was the topic of the most recent meeting. The U.S. Attorney General declared health care fraud as a special initiative throughout the country. Representatives from the U.S. Attorney's Office in Delaware informed the membership about this new Medicare fraud initiative in Delaware. They presented an example of a fraud case and reviewed areas to watch out for and things to avoid. They also informed the members about the Federal False Claims Act, or the whistle-blower's act. Under the act, an individual turning in someone involved in fraud could receive 15-25 percent of any money recovered from the prosecution.

The Board of Directors and Standing Committees held regular meetings throughout the year. I would like to express my appreciation to the Community Affairs Committee, chaired by Dr. Joseph Hacker, the Professional Conduct Committee, chaired by Dr. Richard Winkelmayer, and the Peer Review Commit-



The Annual House of Delegates luncheon brought physicians together for lunch and discussion.

Sussex County Medical Society

tee, chaired by Dr. Forrest Hawkins, for their work during the past year. I would also like to take this opportunity to thank the Board of Directors, members and staff for their help and support during the past year.

Stephen F. Wetherill MD
President

The report was filed.

Sussex County Medical Society

In 1995, as in years past, the Sussex County Medical Society attempted to inform its members of the activities occurring at the state level within our medical society. Our Executive Board hopefully gave our county members a voice on the MSD Board of Trustees. We exchanged ideas and information through our quarterly meetings which rotated in Seaford, Rehoboth Beach, and Milford. Guest speakers included Robert Heyssel MD, retired president of Johns Hopkins University and Hospital. Dr. Heyssel discussed health care reform from the perspective of a large university hospital wrestling with reform and the possible impact on our community hospitals. MSD President Michael J. Bradley DO, updated the county on the current issues facing the state medical society and encouraged continued involvement of our members in society activities. Because part of our role as physicians today involves lobbying efforts for health care legislation, we invited Philip Corrozi, our legislative specialist, to review

the legislative process for our members.

Our Executive Committee received and investigated two complaints from Sussex County residents involving our physicians. As a county society, we elected to support the efforts of Jana Siwek, the *Physicians' Advocate*, through sponsoring the cost of office staff attendance at southern "Advocate" functions. We have attempted to poll the county society members to elicit their desire to serve a more active role within the county and also the state Society. We have witnessed a continued growth within our county membership this year.

The Sussex County Executive Board has enjoyed taking part in the activities of the MSD Board of Trustees. We are hopeful we will be able to encourage other members of the society to remain active in both local and statewide issues affecting their patients, their communities, and themselves through their activities within the Medical Society of Delaware.

We send our support and congratulations to one of our past presidents, Paul Howard MD, for his efforts within the county and for his upcoming role as President-Elect of the Medical Society of Delaware.

Harry A. Lehman III, MD
President

The report was filed.

Representative to the Delaware Academy of Medicine

The Academy's Consumer Health Library provides the

public with access to current health care information in order to promote health education. The library's resources include books, health newsletters, medical journals, referral sources and clipping files. During the past year, the Consumer Health Library filled 2,195 interlibrary loan requests and staff conducted 756 searches. In addition, Health Reference Center, our computerized database, was used by 826 individuals to conduct their own literature/subject searches.

The Lewis B. Flinn Library also provides a full range of services to members including: reference, computer searching, interlibrary loan, faxing, photocopying and discounts on books and journal binding. During 1994, the library filled 12,143 interlibrary loan requests and performed 1,848 computer searches. The Academy's Circuit Riding Medical Librarian Program (CRML) supplies library services to MeadowWood Hospital, HCA Rockford Center, Milford Memorial Hospital, Nanticoke Hospital, Riverside Hospital and St. Francis Hospital.

The library's History Committee, chaired by John M. Levinson MD, has been busy working on the collection and preservation of memorabilia associated with the history of medicine and dentistry in Delaware. The Committee has been actively soliciting historical donations, identifying artifacts, cataloging and putting together a Historical Collection exhibit.

TEL-MED remains a popu-

lar source of information on medical, dental and other health related subjects. Our automated telephone system consists of over 420 tape recorded messages and averages 10,000 calls per month. TEL-MED is provided as a public service statewide.

Our Student Financial Aid Program provides assistance to Delawareans who are pursuing careers in medicine, dentistry or allied health fields through a revolving loan fund. During 1995, 32 students were awarded \$68,500 in loans. The Committee also recommended that 14 Fourth Year Delaware students attending Jefferson Medical College receive \$80,000 in DIMER funds.

We continue to produce and distribute our monthly calendar of *Medical-Dental Meetings in Delaware*. The calendar serves as the only comprehensive listing of continuing education conferences for physicians and dentists in the state.

The Academy's auditorium and conference center were used extensively by the medical and dental professions for meetings. The Medical Society of Delaware, Medical Center of Delaware, New Castle County Medical Society and the Delaware State Dental Society were the primary users of the meeting facilities. However, the facilities were also used by other business, civic and non-profit organizations.

The Executive Committee and Board of Directors manage the Academy's operation and programs through regular meetings. We would like to take this opportunity to thank

Representative to the Delaware Academy of Medicine



Thomas C. Scott MD received the President's Award for his volunteer work with the St. Clare Medical Outreach.

Executive Director's Report

all those individuals and organizations who supported our programs and services during the past year.

Leonard P. Lang MD
Representative

The report was filed.

Executive Director's Report

If I were to give a title to this year's report, it would be: "A Physician Organization's Response to Managed Care." Much of the Society's energies and resources this past year have been focused on the multifaceted issues emerging around us, as managed care gains an increasing foothold in Delaware's medical marketplace.

Society members have responded to the shifting sands of medical practice. Some have formed new physician organizations and networks while others have either joined new, or expanded existing, practice arrangements to better position themselves individually and corporately to meet unknown challenges ahead. To the extent that these organizations represent an effort to proactively influence Delaware's evolving delivery system, they will likely succeed. If they are simply defensive positioning, they will not. A castle is yet to be built with impenetrable walls.

It is within this context of change and uncertainty that the Society has endeavored to chart a course for assisting its members in not only adapting to, but more importantly, influencing the practice environment in our state. As briefly

outlined below, the Society's managed care strategy includes an array of programs and services to empower Delaware physicians to effectively compete in the developing health care arena.

The *Physicians' Advocate* program, implemented just two years ago, is at the heart of the Society's managed care strategy. In addition to practice management consulting in the physician's office, *Physicians' Advocate* conducts workshops for office personnel, fields dozens of inquiries per week from physicians and their office staff, and directly intervenes on behalf of physicians in mediating third party payment issues. A valuable new service was added this year which helps physicians understand the nuances of managed care contracting and more effectively negotiate contract terms and conditions. The Managed Care Contracting Service provides legal review of six different MCO contracts with section by section commentary and advice. These reviews are provided by the attorneys of The Health Care Group, a nationally known practice management and health care consulting firm.

Also formed this year under the auspices of the *Physicians' Advocate* program was the Managed Care Round Table, a group of executives and key staff representing the major managed care plans operating in the state. The Round Table has met twice to exchange ideas on how to standardize the cumbersome and confusing MCO requirements im-



Delegates meet outside the reference committee meetings for some friendly conversation.

posed on physician offices. The Round Table is currently exploring the feasibility of a Society-sponsored centralized credentialing program, which could significantly reduce paper work generated by the ongoing credentialing process. Due to the tremendous success of the *Physicians' Advocate* program, the Society's Long Range Planning Committee is investigating the formation of a Management Services Organization (MSO). The main thrust of an MSO, should it come to fruition, would be to formalize and expand the diverse offering of services currently available through the Society, so that physician practices can become more efficient in an increasingly competitive environment.

As a legislative response to managed care, the Society introduced the Fairness and Choice Under Qualified Health Benefits Plans Act (HB 321) just before the General Assembly recessed in June. Society representatives collaborated with the Delaware Insurance Department in fashioning a bill which creates regulatory oversight over the business practices of managed care plans. Specifically, our legislation would: 1) require the Insurance Commissioner to promulgate regulations governing MCO disclosure of plan terms and conditions, utilization management requirements, and financial arrangements which could influence patient care; 2) preserve patient choice of physician through requiring a "Point of Service" plan to be offered by any MCO doing business in

the State; and 3) provide for due process in the physician selection/deselection process. Each member of the General Assembly has been invited to small group meetings with Society representatives this fall to learn first hand the compelling reasons behind this much needed public policy regarding managed care.

Other Society activities surrounding managed care this year have included increased efforts in public education and awareness. Society representatives have appeared on local television and radio programs and have provided occasional newspaper interviews and commentary on managed care and the changing health care delivery system in Delaware. We have also participated in congressionally-sponsored town meetings on Medicare reform and given presentations to business groups, providing the perspective of the medical profession whenever an opportunity presents itself. Finally, formal meetings are being held periodically between Society leadership and senior management representatives of Aetna, DuPont, the Delaware State Chamber of Commerce and Blue Cross Blue Shield of Delaware to more formally bring the physician's viewpoint directly to corporate and managed care decision makers. This is just a beginning, however, and much greater emphasis is needed in providing public information and education regarding managed care in the coming year.

Although managed care has consumed an enormous amount of our energies during



Dr. Bradley honored many of the members who graduated medical school 50 years ago. Charles Walker Jr., MD receiving his plaque.

"If I were to give a title to this year's report, it would be: 'A Physician Organization's Response to Managed Care.'"

Mark Meister
MSD Executive Director

MEDICAL SOCIETY OF DELAWARE
1995 CONSOLIDATED REPORT
AS OF 9/30/95

REVENUE	1995 BUDGET ALL PROGRA	ACTUAL	PERCENT OF BUDGET
MEMBERSHIP*	307,825.00	299,806.25	97.40%
SERVICES	77,380.00	37,045.50	47.87%
INTEREST/DIVIDENDS	125,586.00	117,607.59	93.65%
CONTRIBUTION	0.00	0.00	-
ADVERTISING	90,948.00	56,066.46	61.65%
SUBSCRIPTIONS	8,035.00	4,100.50	51.03%
CONTINUING MEDICAL EDUCATION	38,400.00	19,013.67	49.51%
ANNUAL MEETING	50,000.00	31,245.00	62.49%
FUND TRANSFER	79,927.00	58,590.18	73.30%
TOTAL REVENUE	778,101.00	623,475.15	80.13%
EXPENSES	1995 BUDGET ALL PROGRA	ACTUAL	PERCENT OF BUDGET
PERSONNEL	389,266.00	253,496.98	65.12%
BOARD/COMMITTEES	15,800.00	12,622.34	79.89%
INSURANCE	5,641.00	3,699.00	65.57%
PRESIDENT'S HONORARIUM	25,000.00	18,749.97	75.00%
MEDICAL DIRECTOR	25,000.00	18,749.97	75.00%
LEGAL COUNSEL	12,500.00	14,023.68	112.19%
ACCOUNTING/AUDIT	6,550.00	6,400.00	97.71%
PUBLIC RELATIONS	33,050.00	27,181.60	82.24%
OFFICE SPACE	18,720.00	12,905.34	68.94%
DOVER OFFICE	2,250.00	1,112.52	49.45%
OFFICE SUPPLIES	4,497.00	2,992.15	66.54%
TELEPHONE	9,649.00	6,068.34	62.89%
POSTAGE	21,983.00	11,854.25	53.92%
PRINTING	62,878.00	47,342.00	75.29%
PHOTOCOPY	6,618.00	2,824.33	42.68%
EQUIPMENT	8,007.00	8,336.11	104.11%
ACCREDITED SERIES CME	9,700.00	3,873.40	39.93%
NON ACCREDITED CME	1,188.00	0.00	0.00%
ANNUAL MEETING	46,000.00	748.02	1.63%
TRAVEL	25,200.00	12,997.41	51.58%
NEWSLETTER	5,100.00	3,554.00	69.69%
DUES/CONTRIBUTIONS	2,750.00	5,420.40	197.11%
SUBSCRIPTIONS	600.00	638.82	106.47%
AUXILIARY	3,500.00	3,500.00	100.00%
DMJ DUES EXEMPT	3,360.00	3,240.00	96.43%
BENEVOLENT FUND	899.00	867.50	96.50%
ROSTER	6,570.00	1,945.73	-
CAPITAL IMPROVEMENTS	0.00	2,174.17	-
MISCELLANEOUS	1,190.00	1,663.96	139.83%
TOTAL EXPENSES	753,466.00	488,981.99	64.90%
SURPLUS (DEFICIT)	24,635.00	134,493.16	

Medical Society of Delaware 1995 Consolidated Budget

1995, the Society's activities remain diverse as ever. The reports contained within the pages of this Delegate's handbook attest to the vibrant posture of your Society on a wide range of issues. Countless hours have been devoted by physicians throughout the state in the work of the Society. It is the active participation by Medical Society of Delaware members which ensures a meaningful contribution by MSD in the lives of its members and the future of the profession. I am privileged to serve this organization at such a dynamic time in the history of Delaware medicine and would like to especially acknowledge my dedicated and hard working co-workers for their tremendous support throughout the year.

Mark A. Meister
Executive Director

The report was filed with special commendation to Mark Meister and to Jana Siwek.

Reports of the Elected Committees

Report of the AMA Delegation

Over the past year, the Delaware Delegation of the American Medical Association has increased its activity and level of organization. There are now specific reference committee assignments and floor assignments for each of the delegates and alternate delegates. In addition, through the budgetary process, the Medical Society of Delaware is

now funding both the delegates' and the alternate delegates' attendance at the annual meeting of the House of Delegates of the AMA. Since this coming year's interim meeting will be in nearby Washington, D.C., the full delegation will attend that also. In addition, the delegation has been involved in cooperative efforts with the Medical and Chirurgical Faculty of the State of Maryland and continues a high level of activity and visibility within the Southeastern Delegation.

In terms of the activities of the House of Delegates over the past year, the AMA House of Delegates has been actively involved in setting policy for the AMA with regard to managed care and its effect on the practice of medicine and the quality of care rendered to the public. Among the changes that have occurred in the AMA policies and procedures are the following:

- The Council on Ethical and Judicial Affairs (CEJA) now has open hearings to allow greater input by AMA members.
- There was a bylaws change to create a Trustee-level position for a young physician.
- AMA policy has been strengthened with regard to gun control.
- A policy was passed recommending that at least one worker at every day care center be trained in CPR and in the Heimlich maneuver.
- Support of needle exchange programs to control AIDS among I.V. drug

Reports of the Elected Committees



Elenora Schneider MD received a plaque from Dr. Bradley.



Rhoslyn J. Bishoff MD became the second recipient of the Daniel A. Alvarez Distinguished Service Award, dedicated to the memory of one of the Society's past presidents.



Gerald Savage MD smiled as he received his honorary 50 year plaque from Michael J. Bradley DO.

abusers and abolition of television advertising of alcoholic beverages.

- The addition of the gram stain as a waived test under CLIA.
- A prohibition against managed care organizations and other organizations using physician DEA numbers for reasons other than controlled substance prescribing.
- A position against the performance by some cultures of female circumcisions/mutilation.
- Heightening of the awareness among minorities to become bone marrow transplant donors.
- Approval of the use of non-inhaled derivatives of marijuana for patients with terminal or intractable diseases.
- Support of the revised Patient Protection Act that would assure choice to patients and due process to physicians when dealing with managed care organizations.
- A policy against and a detailed program aimed at preventing domestic violence and sexual abuse.
- A resolution to express strong opposition to the Weekly Reader's presentation of biased, unbalanced information with regard to children about smoking.
- Support for the development of nontraditional sites for student and resident training, such as nursing homes, outpatient clinics, physician offices, HMOs, etc.

- A policy to promote and encourage primary care summer internships for medical students.
- An AMA policy to urge third party payers to eliminate restrictions on mental health and chemical dependency treatment benefits.

There was also discussion about the AMA's budget. Over the past couple of years, the AMA's budget has been on the decline with significant losses during the past fiscal year. This was due primarily to a change in advertising revenues from pharmaceutical companies in the various AMA journals. Because of some of the changes in regulations concerning advertising by the FDA, there has been a marked decline in pharmaceutical advertising in the various AMA journals. This has greatly reduced revenue and has created the need for organizational changes to reflect these declines for the AMA. The budgetary plans presented at the House of Delegates meetings would indicate that these changes will be reflected in a balanced or a revenue generating budget in the near future.

In addition, the mechanism for the replacement of James Todd MD, as Executive Vice President and CEO of the AMA, was outlined. It is fully anticipated that early in 1996, Dr. Todd's replacement will be on board for a transition, fully replacing him by the annual meeting in June of 1996.

The full proceedings of the House of Delegates are available in the Society office and any member who would like to

review them or receive any portion of them are welcome to call the office.

The AMA House of Delegates meetings continue to provide a unique democratic opportunity for your representatives to express their opinions along with those of other physicians around the country on a wide variety of matters essential to the appropriate delivery of health care in our country. Any member of the Society is welcome to attend these meetings and to present testimony at the various reference committees, and the Delaware delegation welcomes any or all of you to take advantage of this opportunity. Furthermore, we encourage you to present to the Board of Trustees of the Medical Society of Delaware any resolutions that you may have for the AMA House. Your delegates will do their best to express your views and get approval for those resolutions at the AMA House meetings.

Stephen R. Permut MD
Senior Delegate, AMA

The report was filed with commendation to Dr. Permut for his hard work and the recommendation to the Board of Trustees that the Public Laws Committee be asked to draft legislation to support mandatory CPR training of day care workers as one of the top items that was suggested from the AMA and that the Society commend and thank Dr. James Todd for all his hard work and help

to the Medical Society of Delaware.

Budget and Finance Committee

The committee met two times this year. At the first meeting in July, the preliminary budget projected a substantial deficit. Two main reasons for this were expansion of the *Physicians' Advocate* position to a full-time position, including an assistant for that position, as well as uncertainty as to the MSDIS dividend. Additionally, advertising revenues from the *Journal* had an unexpected downturn.

It was recommended at that time, therefore, that:

- A redefined projection of MSDIS potential dividend and contribution be evaluated by Haggerty and Haggerty;
- The Publications Committee explore ways of reducing the *DMJ* advertising deficit.

There was also a discussion concerning the Society's investment performance in our Compuval and Greenville Management with Mr. Nickle of Dean Witter. The Society's investments have appreciated in value from \$376,560.00 in July of 1992 to \$664,305.66 as of September 1995, representing growth of 82 percent. Mr. Nickle also commented on a loss sustained by the Society's short term investments of \$18,484.00 on \$263,000.00 invested in a North American Bond Trust in 1993 which occurred because of the devaluation of the peso; 25 percent of that fund was invested in Mexican bonds.

Budget and Finance Committee

IN TRIBUTE

The following members of the Medical Society of Delaware were honored at the House of Delegates' luncheon for graduating from medical school 50 years ago:

James P. Aikins MD
Rhoslyn J. Bishoff MD
W. Pierce Ellis Jr., MD
Lloyd B. Harrison Jr., MD
Harold J. Laggner MD
Ernest M. Larmore MD
James R. McNinch MD
Gerald J. Savage MD
Elenora Schneider MD
Jurg A. Schneider MD
Charles Strahan Jr., MD
Charles Walker Jr., MD



MSDNet's Keith Duncan was on hand to introduce physicians to newest MSD member benefit.

There was also discussion concerning the amount of commissions charged by Dean Witter. Accordingly, the committee asked Mr. Nickle to revisit the subject of commissions paid for stock transactions. (Both Greenville and Compuval trade individual stocks, and commissions must be paid to a broker.) It was also recommended that other investment managers be contacted for this purpose, as well. Finally, the committee recommended at that time that the Society's investments remain with Compuval and Greenville.

The second meeting was October 11, 1995. The budget was approved at that time. After discussions with Haggerty and Haggerty and MSDIS, a conservative estimate of \$130,000.00 dividend plus a contribution of \$20,000.00 to the Delaware Medical Education Foundation was placed into the budget. This will be firmed up as of December 31, 1995. In addition, several points also need to be noted.

- *Physicians' Advocate* revenue has been budgeted at current levels, although increases in staffing, which increase the expense side of the budget, may well result in additional revenue.

- The *Delaware Medical Journal* revenues have been analyzed closely and advertising revenues appear to be at last year's level at this time, which would only bring a very small deficit.

- Several new initiatives under consideration by the Board of Trustees may add additional revenues. These include central credentialing services and

a medical services organization. These are not included in the budget.

- The committee recommended use of reserve funds as seed money to develop these and other new initiatives which may have potential for revenue generation.

Additionally, the budget includes a 3 percent cost of living adjustment for the staff and \$22,215.00 for the biannual publication of the roster, in addition to the increased cost of the Physicians' Advocate program as has been previously mentioned. Also noted is budgetary allowance for upgrade to an existing computer and the need to purchase a printer for the accounts payable program which has been planned for next year. The budget now has a small projected deficit and there is no need for a dues increase.

Banking and Investments Accounts asset appreciation in the Greenville and Compuval accounts are \$534,942.00 and \$129,363.66, respectively for the last year. Since inception, the accounts have increased 93 percent and 23 percent respectively.

Mark Meister and I have met with four investment managers and the committee is continuing to evaluate their recommendations, in order to keep the cost as low as possible for our investment program.

I would like to thank all the staff, especially Jean Gayle and Mark Meister for their help in daily operations, as well as budget projections. Additionally, many thanks go to the committee, especially

Anthony L. Cucuzzella MD; William H. Duncan MD; Stephen S. Grubbs MD; Ali Z. Hameli MD; Thomas J. Maxwell MD; William L. Medford Jr., MD; and Janice E. Tildon-Burton MD, for their invaluable contributions.

Garth A. Koniver MD
Chair

The report was filed with special commendation to Jana Siwek for her energetic efforts with the *Physicians' Advocate* Program and to Mark Meister, Executive Director, for his devoted efforts for the Medical Society of Delaware.

Committee on Ethics

The Committee on Medical Ethics meets quarterly and had sessions in March, June and September 1995. The last meeting is scheduled for December 13, 1995.

As stated in the Bylaws of the Medical Society of Delaware, the function of the committee is "to consider and make recommendations to the Board of Trustees for

formal policy statements on issues concerning the ethics of medical practice, the profession and health care delivery; to investigate ethical problems pertaining to the relations of physicians to one another or to the public and make recommendations to the Board; and to be responsible for investigative and disciplinary procedures outlined in Article XIV of the Bylaws."

There were no disciplinary procedures referred to this committee during 1995.

REVENUE	ADMINISTRATIVE BUDGET	PHYSICIANS ADVOCATE	COMPONENT SOCIETIES	DMJ BUDGET	CME & PHYS HLTH	VIP BUDGET	1995 BUDGET ALL PROGRAMS
MEMBERSHIP	\$304,895	\$0	\$0	\$9,920	\$0	\$0	\$314,815
SERVICES	63,095	12,675	6,562	0	0	0	82,332
INTEREST/DIVIDENDS	145,260	0	0	928	0	0	146,188
ADVERTISING	0	0	0	81,775	0	0	81,775
SUBSCRIPTIONS	0	0	0	5,592	0	0	5,592
EDUCATIONAL PROGRAMS	0	19,400	0	0	33,870	0	53,270
ANNUAL MEETING	0	0	0	0	50,000	0	50,000
FOUNDATION TRANSFER	0	0	0	0	20,000	43,875	63,875
TOTAL REVENUE	\$513,250	\$32,075	\$6,562	\$98,215	\$103,870	\$43,875	\$797,847
EXPENSES	ADMINISTRATIVE BUDGET	PHYSICIANS ADVOCATE	COMPONENT SOCIETIES	DMJ BUDGET	CME & PHYS HLTH	VIP BUDGET	1995 BUDGET ALL PROGRAMS
PERSONNEL	\$243,179	\$60,878	\$1,817	\$29,416	\$23,160	\$32,585	\$391,036
BOARD/COMMITTEES	15,000	625	0	0	1,264	300	17,189
INSURANCE	3,952	0	0	865	865	644	6,325
PRESIDENT'S HONORARIUM	25,000	0	0	0	0	0	25,000
MEDICAL DIRECTOR	0	0	0	0	25,000	0	25,000
LEGAL COUNSEL	14,000	6,000	0	0	255	0	20,255
ACCOUNTING/AUDIT	3,856	0	0	844	1,244	1,082	7,025
PUBLIC RELATIONS	34,043	0	0	0	0	0	34,043
OFFICE SPACE	10,849	344	0	2,411	2,411	2,705	18,720
OFFICE SUPPLIES	2,560	75	150	810	560	370	4,525
TELEPHONE	2,429	0	25	531	1,439	3,232	7,656
POSTAGE	11,604	25	2,000	5,242	1,882	1,076	21,829
PRINTING	1,844	100	0	60,811	1,153	231	64,140
PHOTOCOPY	4,301	1,732	1,170	390	1,930	112	9,635
EQUIPMENT	10,395	0	0	2,275	2,275	1,338	16,282
ACCREDITED CME	0	0	0	0	8,550	0	8,550
WORKSHOPS	0	8,259	0	0	0	0	8,259
ANNUAL MEETING	0	0	0	0	46,000	0	46,000
TRAVEL	24,000	1,000	0	0	600	100	25,700
NEWSLETTER	5,100	0	0	0	0	0	5,100
DUES/CONTRIBUTIONS	5,870	50	0	100	695	0	6,715
SUBSCRIPTIONS	765	0	0	0	0	0	765
ALLIANCE	3,500	0	0	0	0	0	3,500
DMJ DUES EXEMPT	3,400	0	0	0	0	0	3,400
ROSTER	22,215	0	0	0	0	0	22,215
BENEVOLENT FUND	924	0	0	0	0	0	924
MISCELLANEOUS	350	0	0	300	100	100	850
TOTAL EXPENSES	\$449,136	\$79,088	\$5,162	\$103,994	\$119,383	\$43,875	\$800,638
SURPLUS (DEFICIT)	\$64,114	(\$47,013)	\$1,400	(\$5,779)	(\$15,513)	\$0	(\$2,791)

Medical Society of Delaware 1996 Consolidated Budget



The popular puzzle piece contest run by MSDIS, Zutz/PLI had many physicians hopeful of winning special baskets. The three winners were: Charles Konigsberg Jr., MPH MD, Thomas J. Maxwell MD, and Sadashiva S. Rao MD.

Committee on Ethics

The first meeting of the committee was held on March 22, 1995. The guest speaker was Dr. Paul Durbin, Professor of Philosophy at the University of Delaware and a member of this committee. His presentation was titled: "Arriving at an Ethical Decision: A Philosophical Roadmap." The discussion was centered around a paper by Dr. Edmund Pellegrino published in J.A.M.A. on March 3, 1993, "The Metamorphosis of Medical Ethics, a Thirty-Year Retrospective," which reviews medical ethics from the Hippocratic era, through the periods of Principalism, Antiprincipalism, and the years of crisis that await us.

Dr. Durbin presented a "roadmap" describing the methods of ethical argumentation and proposed means of resolving systematic differences.

On June 28, 1995, the second meeting was held. The speaker was Robert G. Kettrick MD, Chairman of the Department of Critical Care at the A.I. DuPont Institute, past Chairman of its Bioethics Committee, and presently Vice Chairman of the Delaware Health Care Committee. His presentation focused on the changes that are taking place in the delivery of health care as a result of the increasing control by the new power-players, such as the big corporations, insurance companies, labor, and the government. Dr. Kettrick placed emphasis on the need to be attentive to quality issues as these changes are taking place.

The third meeting was held on September 27, 1995. The

speaker was Dr. Daniel DePietropaolo, Program Director of the Family Practice Residency Program at the Medical Center of Delaware and also a member of this committee. The subject of this presentation was, "The Living Will Issue and Delaware Senate Bill No. 72." Dr. DePietropaolo noted that Delaware's present law was passed in 1983 and is now obsolete when compared with similar laws in New Jersey and in Pennsylvania. He also informed the committee of a recent Delaware Supreme Court decision that affirmed the judgment of the Court of Chancery in granting authorization to the petition for a relative allowing her to die.

The fourth and last meeting for 1995 is scheduled to be held on December 13, 1995. The undersigned will be the speaker. The presentation is titled: "Is Managed Care Ethically Correct...?" Since managed care has significantly changed the delivery of health care in Delaware, this meeting promises to create a heated debate.

Maurice Liebesman MD
Chair

The report was filed.

Judicial Council

During the past year, the Judicial Council was called upon to review four requests for dues exemption. Three requests were granted, and one was denied.

No other issues have been referred to the Judicial Council in the last year.

I. Favel Chavin MD
Chairman

The report was filed.

Reports of the Standing Committees

Bylaws Committee

The Bylaws Committee met in October to discuss several matters relating to the Bylaws of the Medical Society of Delaware.

Consideration of Affiliate Membership for Physician's Assistants

This issue was referred by the Board of Trustees following a suggestion, in light of the Society's positive working relationship with the Delaware Academy of Physician Assistants (DAPA) and the fact that DAPA is committed to the continuing dependent provider status of physician's assistants in Delaware, that a non-voting affiliate status be created for physician's assistants. In several other state medical societies, physician's assistants are eligible for such membership status. Following discussion of this matter, the committee agreed to draft an amendment to Article III (Membership) of the Bylaws to permit affiliate membership in the Society for physician's assistants who are licensed in Delaware, who belong to their own professional society (DAPA), and who are supervised by a physician who is a member of the Medical Society of Delaware.

Young Physicians Section Bylaws

Provision for a Young Physi-

cians Section was also referred by the Board of Trustees. It was noted that the present Bylaws provide that the Board of Trustees shall include "one representative from a duly formed Delaware Chapter of the Young Physicians Section of the American Medical Association." This is the only reference to the Young Physicians Section in the Bylaws. Dr. Stephen Grubbs provided background on the AMA's Young Physicians Section, which includes physicians under age 40 or within the first five years of professional practice after residency and fellowship training programs. This section provides input to the AMA's Board of Trustees and the House of Delegates, and the AMA has urged the states to form Young Physicians Sections. Dr. Grubbs has offered to help with organizing the section.

The committee supported amending the Society's Bylaws to provide for a Young Physicians Section with the same definition for membership as the AMA but felt the group should be allowed to write its own bylaws with the proviso that they not be in conflict with those of the parent organization. An amendment to Article III (Membership) has been drafted. The committee also agreed that the existing Bylaws reference should be amended for consistency.

New Membership Category

A situation regarding a potential member in one of the county medical societies has raised the issue of a member-

Reports of the Standing Committees



Kent Evans of MSDIS/Health Select explained the benefits of MSD insurance.



MSD members shown leaving the scientific session. The Annual Meeting allowed members and guests to hear talks from several nationally renowned speakers.



Stephen L. Eck MD, PhD, presented "Advances in Cancer Gene Therapy."

Proposed Amendments - Medical Society of Delaware Bylaws

ship category for physicians who move to Delaware but are not licensed to practice medicine in the state. Dr. Norman Taub noted that this may happen more frequently in the future as retired physicians move to Delaware and desire to become courtesy members of the Society. The committee supported an amendment to the Article III (Membership) to permit affiliate membership for a physician who moves to Delaware but is not licensed in the state as long as the physician is licensed in another state and is a member in good standing of another state medical society.

Vice Speaker of the House of Delegates

Consideration of establishing the office of Vice Speaker of the House of Delegates was referred by the Nominating committee, which suggested that it would be helpful to have a Speaker "in training" as well as someone who could officiate in the Speaker's absence as well as assist with the reference committees. The committee agreed that the Vice Speaker, like the Speaker, should be a voting member of the Board of Trustees. A Bylaws amendment to provide for a Vice Speaker has been drafted.

A summary of the Bylaws amendments proposed by the Bylaws Committee is included with this report.

Dene T. Walters MD
Chair

The four Bylaws changes recommended by the committee were voted on separately and were adopted by the

House of Delegates.

Proposed Amendments - Medical Society of Delaware Bylaws

The following proposed Bylaws amendments are submitted by the Bylaws Committee. ~~Strikeouts~~ indicate deletions, and *[italicized text in brackets]* indicates additions or substitutions.

ARTICLE III, Membership, Section 3, Active Members

Physicians with an unrestricted license to practice medicine and surgery who are registered in the state of Delaware to practice medicine in all its branches, who are of good moral character and professional standing and who are active members in good standing of their component society shall be eligible for active membership. Active membership in the state society is mandatory for active members in a component society.

[Active members who have been in practice for fewer than five years after completing training or are under the age of 40 are eligible to be part of the Delaware Young Physicians' Section of the American Medical Association. The Young Physicians' Section may write separate bylaws, which however may not be in conflict with these Bylaws and which must be approved by the Board of Trustees. They may accordingly elect their own officers, conduct separate meet-

ings, and nominate a member of the Board of Trustees.]

ARTICLE III, Membership, Section 6, Affiliate Members

Affiliate members may be:

(a) medical students, interns or residents, or postdoctoral trainees serving in an accredited educational program recognized by this Society and other house physicians with restricted licenses.

(b) former members of this Society who no longer practice and reside in Delaware, provided they currently maintain active membership in the state medical society of their new state of residence.

(c) physicians who are licensed in Delaware but are active members of other state medical societies.

[(d) physicians who reside but are not licensed in Delaware but who are licensed in another state and who are members in good standing of another state medical society.]

[(e) physician's assistants who are licensed in Delaware and are members in good standing of the Delaware Academy of Physician Assistants and who are supervised by a physician who is a member of the Medical Society of Delaware.]

Affiliate Members may be required to pay membership dues and shall enjoy the privileges of this Society, except as provided in Sections 7 and 8, without the right to vote or hold office, unless otherwise specified in these Bylaws.

The dues for affiliate members shall be set annually by the House of Delegates upon recommendation of the Budget Committee.

ARTICLE V, Officers, Section 1, Named

The officers of this Society are the President, President-Elect, Vice President, Secretary, Treasurer, Speaker **[and Vice Speaker]** of the House of Delegates, and Executive Director. The Executive Director shall be a member ex-officio without vote of all elected, standing and special committees, and shall not be subject to the rules of qualification, election, and tenure that apply to other officers within these Bylaws.

**[Section 12, Vice Speaker
The following rights and duties devolve on the Vice Speaker:**

(a) **to officiate for the Speaker in the latter's absence or at the request of the speaker;**

(b) **in the event of vacancy in the office of Speaker, to officiate during the unexpired term;**

(c) **the Vice Speaker shall be entitled to vote when the vote is by ballot. Otherwise, when officiating for the Speaker or when filling a vacancy in the office of Speaker, the Vice Speaker shall have the right to vote only in case of a tie.]**

ARTICLE VI, House of Delegates, Section 2, Composition
The House of Delegates shall be composed of: (1) delegates



J. P. Mohr MD gave the presentation entitled "Management of Stroke."



Bruce Ettinger MD gave two scientific sessions, "Detection and Clinical Evaluation of Osteoporosis," and later in the day, "Risks and Benefits of Hormone Replacement Therapy."

Long Range Planning Committee

elected by the component societies, each component society being entitled to elect one delegate for every 10 active members in good standing as of June 1, or major fraction thereof, provided each component society shall be entitled to elect at least one delegate; (2) the President, President-Elect, Vice President, Secretary, Treasurer, Speaker [*and Vice Speaker*] of the House of Delegates, all Past Presidents, the elected Trustees, the AMA Delegates, the alternate AMA Delegates, the presidents of the county medical societies and the Editor of the Society's official publication.

ARTICLE VIII, Board of Trustees, Section 2, Composition

The Board of Trustees shall consist of:

(a) the Trustees elected by the component societies, the number of which shall be one trustee per one hundred, or fraction thereof, of the membership but not less than two per county.

(b) the presidents of the county societies.

(c) one representative from the affiliate members representing approved post-doctoral training programs within the state. Nominations for this position will be sought annually and appointment made by the Board of Trustees.

(d) the President, President-Elect, Vice President, Immediate Past President, Secretary, Treasurer, Speaker [*and Vice Speaker*] of the House of Delegates, Delegates to the American Medical Association, and the Editor of the Society's official publication.

(e) one representative from a duly formed Delaware ~~Chapter of the~~ Young Physicians' Section of the American Medical Association. Nominations for this position will be sought annually and appointment made by the Board of Trustees.

Long Range Planning Committee

Prior to this year, the most recent involvement of the Long Range Planning Committee was in the area of physician office computerization, a project that is still ongoing. It has become apparent, however, that the Society is in need of a long range plan to enable the Society to adapt to the ever-changing medical environment. Managed care proposed government reforms of Medicare and Medicaid call for a medical society that is pro-active not only for the physicians but for the physicians' patients. The initial February 22, 1995 meeting of the Long Range Committee outlined goals regarding the establishment of a management services organization within the framework of the Medical Society of Delaware.

Meetings were held with Roger Mecum from the Pennsylvania Medical Society regarding their implementation of a management services organization (MSO) and how Delaware could be involved in such an organization.

On May 24, 1995, a joint meeting of the Executive Committee of the Medical Society and the Long Range Planning Committee was held with a presentation given by Mr. Mecum.

Mr. Mecum described the steps taken by the Pennsylvania Medical Society to establish an MSO. The consulting firm of KP&G was hired by the Pennsylvania Medical Society to establish a strategic plan for guiding the society in becoming more pro-active in issues concerning managed care. After approval of the House of Delegates in October 1994, an MSO became operational in January 1995. It operates as a for-profit subsidiary of the Pennsylvania Medical Society and has hired a full-time CEO. Through the MSO, physicians would first organize and arrange for horizontal integration to promote interdependence that would be both primary and a multi-specialty care. The MSO would then become pro-active in issues concerning managed care and dealing with managed care organizations with the MSO as the *Physicians' Advocate*.

It is the feeling of the committee that the Medical Society of Delaware alone does not have the capital necessary to establish its own MSO and contracting with Pennsylvania may be a viable alternative.

On September 6, 1995, another combined meeting of the Executive Committee and the Long Range Planning Committee was held and a presentation was given by Mr. John Odessa, Chief Executive Officer, and Joseph Singer MD, Chief Medical Officer of First Options Health Plan of Bergen, New Jersey. First Options is a health plan 100 percent owned by 8,000 New Jersey physicians and 52

hospitals in New Jersey. First Options has also been approved by the Medical and Chiurgical Society of Maryland and is currently establishing plans in Pennsylvania and New York. A detailed description of the First Options Plan was given by Mr. Odessa during which he described the plan as using 84 percent of the premium dollar for health care, nine percent for administration, five percent for dividends, and two percent for reserves in re-insurance. Mr. Odessa further mentioned that Delaware is essential to its strategic plan, which calls for a regional presence with establishment of a First Options Plan in Delaware to be owned directly by Delaware physicians and hospitals.

Following the presentation, there was discussion by the Executive Committee and the Long Range Planning Committee and also invited guests, Peter Shanley, Esquire, and Joseph Letnaunchyn, President of the Association of Delaware Hospitals.

A recommendation was sent to the Board of Trustees of the Medical Society that further evaluation of First Options be undertaken and, if appropriate, funds be allocated for performance of an in-depth study regarding the legal, actuarial, and marketing aspects of the First Options proposal.

It is further recommended that the Board of Trustees and the Long Range Planning Committee continue to investigate the Pennsylvania Medical Society MSO business plan.

There is ongoing involve-



The smiling face of 1995 MSD President Michael J. Bradley DO greeted members and guests to the 206th Annual Meeting.

Medical Liability Committee



Governor Thomas Carper, 1996 MSD President Carol A. Tavani MD, and Henry W. Foster MD, gather for a picture during the Annual Meeting.

ment by the Medical Society with representatives from the leading managed care organizations in Delaware regarding credentialing. At the present time, each company does its own credentialing, increasing the already large administrative burden on physicians' offices caused by managed care. Meetings are being held to establish the type of central credentialing mechanism whereby one organization, quite possibly the Medical Society or its representatives, would be responsible for credentialing with all the major managed care organizations participating in this credentialing. If successful, this would eliminate the need for the periodic credentialing required on an individual basis by each managed care organization.

There is further involvement to establish a Community Health Information Network or CHIN. The CHIN would give providers and payors access to administrative, demographic, and clinical data on patients community-wide. The original Subcommittee for Physician Office Computerization had this as an eventual goal and through the establishment of a CHIN, this goal is being further pursued.

As noted in this report, the Long Range Planning Committee has various, but important tasks to take the Medical Society into the next millennium. And, in summary, the most important of these are:

- the establishment of a physicians' service organization;
- possible involvement

with First Options to establish a physician-hospital organization on a state-wide basis; and

- central credentialing and cooperation with managed care organizations for a Community Health Information Network.

Anthony L. Cucuzzella MD
Chair

The report was filed with commendation to Dr. Cucuzzella for his outstanding efforts with this important committee concerning the long range planning of the Medical Society.

Medical Liability Committee

There was a joint meeting of the MSDIS and Medical Liability Committee on June 12, 1995. Also present were representatives of PHICO Insurance Co., who announced the formation of an Eastern Regional Office that will consolidate risk management, marketing, and claims operation in order to develop new services and be more flexible and responsive.

PHICO announced a new physician's discount, 15 percent claims free discount, a leave of absence discount, prior acts coverage, shared limits of liability for corporations, and part-time credit for physicians over 60 years. The finance charge will be two points under prime. PHICO is developing new programs and policies in response to the growth of managed care. Since

many of these programs were not well known, they should be publicized. More aggressive marketing will also be done by PHICO.

In view of an increase in Delaware loss ratios and a "bad year" in 1989, no dividends will be forthcoming this year. A rate increase will not occur this year, but if losses and expense are kept under control, there might be a small decrease.

PHICO will increase its commission to MSDIS to be more consistent with its competitors.

There are now 376 physicians insured by PHICO in Delaware, and it appears that PHICO and Princeton will be the major carriers for liability insurance in Delaware.

Many thanks to the committee members, Beverly Dieffenbach and Mark Meister, for all their help.

Another meeting is scheduled for October 30, 1995.

James Beebe, Jr. MD
Chair

The report was filed.

Medical Review Committee

There were no requests during the past year for review and resolution of differences in regard to a proper professional fee for services rendered. The Medical Review Committee will review such cases provided: a) each of the disputants agrees to participate on a purely voluntary basis; (b) all determinations will be advisory in nature; (c) the decision in each case will be based

solely on the facts and circumstances of the particular case; and (d) all proceedings will be conducted on a confidential basis and the decision will not be distributed beyond the disputants. The Society will not collect information on medical fees nor conduct surveys of fees.

Anthony L. Cucuzzella MD
Chair

The report was filed.

Program Committee

The Program Committee hereby records for the official record the program arranged for the Annual Scientific Session of the Medical Society of Delaware on November 18, 1995. The objective of this annual program is to update Delaware physicians in a broad range of specialties on significant advances in selected areas of medicine.

206th Annual Meeting

Saturday, November 18, 1995
Hotel du Pont, Wilmington, Delaware

7:30 a.m.

DETECTION AND CLINICAL EVALUATION OF OSTEOPOROSIS

Bruce Ettinger MD

8:30 a.m.

MANAGEMENT OF STROKE

J. P. Mohr MD, Sciarra Professor of Neurology, Columbia University College of Physicians and Surgeons, New York, New York

9:30 a.m.

RISKS AND BENEFITS OF HORMONE

REPLACEMENT THERAPY

Bruce Ettinger MD, Senior Inves-

Medical Review Committee

Program Committee

**Public and
Professional
Education and
Advocacy
Committee**

tigator, Division of Research, Kaiser Permanente Medical Care Program, Oakland, California; Clinical Professor of Medicine and Radiology, University of California Medical Center, San Francisco, California.

10:30 a.m.

INTERMISSION — EXHIBITS

11:00 a.m.

**ADVANCES IN CANCER
GENE THERAPY**

Stephen L. Eck MD, Ph.D., Director of Cancer Gene Therapy Programs; Assistant Professor of Medicine, Division of Hematology/Oncology, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania

12:00 noon **LUNCH — Gold Ballroom**

12:30 p.m.

**STATE AND NATIONAL
CONCERNS WITH
TEENAGE PREGNANCY**

Henry W. Foster, Jr. MD, Dean of the School of Medicine and Professor of Obstetrics and Gynecology, Meharry Medical College, Nashville, Tennessee; President Bill Clinton's nominee for U.S. Surgeon General

Dr. Foster will be introduced by Governor Tom Carper.

1:30 p.m. **ADJOURNMENT OF
SCIENTIFIC PROGRAM**

The Medical Society of Delaware is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The Medical Society of Delaware designates this continuing medical education activity for 4.5 credit hours in Category 1 of the Physician's Recognition Award of the

American Medical Association. One credit hour may be claimed for each hour of participation.

This program has been reviewed and is acceptable for 4.5 Prescribed hours by the American Academy of Family Physicians.

It is the policy of the Medical Society of Delaware to comply with the ACCME Guidelines for Commercial Support of Continuing Medical Education. In keeping with these standards, all faculty participating in continuing medical education programs sponsored by the Medical Society of Delaware are expected to disclose to the program audience any real or apparent conflict of interest related to the content of their presentations.

Steven L. Edell DO, FACR
Chair

The report was filed with commendation to Dr. Edell and his committee for an excellent program.

**Public and Professional
Education and Advocacy
Committee**

The Public and Professional Education and Advocacy Committee (PPEAC) met regularly during the fiscal year. The attention of the committee was mainly directed toward the continuing medical education program of the Medical Society of Delaware.

As of October 18, 1995, with the approval of the Educational Activities Subcommittee (EAS) of the PPEAC, the Medical Society has desig-

nated 36 activities, representing 245 individual sessions, for CME credit this year. The Medical Society was able to sponsor all programs presented for review, as the criteria for CME Category 1 credits were met.

The committee met with Rhoslyn J. Bishoff MD, to discuss the concept of a program about the prevention of domestic violence, including elder and child abuse. This one-day program would be open to the public, physicians (for CME Category 1 credit), and lawyers (for bar association credit) and would feature four to six local speakers. The PPEAC supported joint sponsorship by MSD and the Bar Association of this program and recommended allocating whatever funds are available to the program.

The PPEAC began work on a proposed Speakers' Bureau in conjunction with the Division of Services for Aging and Adults with Disabilities. The bureau will be handled in conjunction with the School Health Talks program since many of the speakers will be chosen from the same pool of volunteers. The committee also recommended working with Volunteers for Adolescent Pregnancy Prevention (VAPP), which has asked for participation by physicians from the School Health Talks program in its school and community presentations. David Platt MD, has agreed to work as a liaison between the MSD and VAPP. MSD will make the contacts for these programs and oversee the arrangements. The Society's

newest employee, Lauryn Harkness, will be the MSD contact person for the programs.

The PPEAC was in favor of jointly sponsoring Category 1 CME programs. (Joint sponsorship is an arrangement in which an accredited sponsor jointly sponsors a CME activity with a nonaccredited entity and in which the accredited sponsor accepts responsibility that the ACCME Essentials are met.) Guidelines for joint sponsorship will be reviewed in the coming weeks. As the Society's CME Guidelines are defined, there would be virtually no difference in the application process other than the terminology. The ACCME will be advised of this decision as soon as guidelines have been finalized.

At its last meeting, the PPEAC discussed revision of the Society's CME mission statement. At the last site visit, the ACCME commended the Society's CME program but recommended that the mission statement be strengthened by making it relate more directly to the ACCME Essentials. The revised mission statement that accompanies this report outlines the Society's CME program and is being submitted for formal approval by the House of Delegates.

The Medical Society's education program, which was awarded accreditation by the Accreditation Council for Continuing Medical Education in May 1992, will be resurveyed in the spring of 1996.

The Medical Society of Delaware continues to be the



Governor Carper shakes hands with 1995 MSD President Bradley. Carper was on hand to introduce Dr. Foster's talk on teenage pregnancy.



Members of the MSD Alliance met for the spouse's program in the Greenville Suite.

accrediting organization of the Delaware Continuing Medical Education Lecture Series for physicians. During the 1995-1996 year, Beebe Medical Center, Nanticoke Memorial Hospital, and Kent General Hospital are participating.

Virginia U. Collier MD
Chair

The report and the Medical Society of Delaware CME Mission Statement were adopted.

Medical Society of Delaware CME Mission Statement

Incorporated in 1789, the Medical Society of Delaware was founded to promote the science and the art of medicine among its members, to uphold the ideals and the ethical principles of the medical profession, to enhance the betterment of the public health, and to enlighten the public at large on medical matters of general and special concern. As a state medical society, we are uniquely positioned to promote the best possible care for patients by assisting physicians in maintaining updated competence through continuing medical education.

The CME activities of the Medical Society of Delaware are defined by the following considerations:

Goal

- To provide educational activities that serve to maintain, develop, and increase the knowledge, skills, and professional performance of physicians in accordance

with the Essentials of the Accreditation Council for Continuing Medical Education.

Audience

- The educational programs are designed primarily to meet the needs of physicians in Delaware, although some programs may attract participants from neighboring states. All programs present a level of knowledge appropriate to physicians.
- Occasionally the target audience may include other health-care professionals as well as other interested members of the public.

Scope

- The Medical Society of Delaware is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians and is responsible for designating activities for credit in Category 1 of the Physician's Recognition Awards.
- The Society may engage in selective cosponsorship and joint sponsorship with hospitals and other health care organizations and associations that share a common educational objective.

Activities

- Annual scientific session to update members of the Society on significant advances in selected areas of medicine.
- Annual Downstate Hospital Lecture Series, cospon-

sored with Jefferson Medical College.

- Other formal conferences, lectures, grand rounds, teaching rounds, departmental scientific meetings, seminars, and workshops designed to meet documented needs, with possible future use of other teaching approaches such as video and audio conferences.

The Medical Society of Delaware through its Public and Professional Education and Advocacy Committee is responsible for oversight of accredited Continuing Medical Education programs for physicians and for compliance with the Essentials and Standards of the ACCME and the AMA's Council on Ethical and Judicial Affairs opinion on gifts to physicians from industry.

Public Laws and Legislative Actions Committees

A summary of 1995-1996 health-related legislation in Delaware and its status as of 8/1/95 is available from the Medical Society. It contains 15 pieces of Senate legislation and 41 House bills.

The only bill of special significance on the Senate side is Senate Bill 72, relating to advanced health care directives, which was introduced by Senator McBride. The Medical Society of Delaware supports the substitute bill, which has a surrogate provision. SS1 for SB 72 passed the Senate on 6/8/95 and at the present is in the House Health and Human Development Committee.

There are a few bills of importance on the House side. They are:

House Bill 57, to require bicycle riders under age 16 to wear safety helmets, introduced by Representative Oberle. The Medical Society supported this bill, which was signed into law by the Governor on 5/23/95 with House Amendment #2.

House Bill 124, to provide immunity for physicians and nurses who volunteer services for persons without insurance, introduced by Representative Di Pinto. This bill, which was introduced at the initiative of the Medical Society of Delaware, was voted out of committee on 5/31/95 and laid on the table as of 6/27/95.

House Bill 259, to regulate optometrists' prescriptive authority under the Board of Medical Practice, introduced by Representative Oberle. The Medical Society supports this bill, which is currently in the hands of the Labor Committee.

House Bill 321, Fairness and Choice under Health Benefits Plans, introduced by Representative Maroney. This is the Medical Society's bill. It is now in the House Economic Development, Banking and Insurance Committee.

House Bill 340, to provide parity of health insurance benefits for mental and physical illness, introduced by Representative Maroney. This is another of the bills introduced by the Medical Society of Delaware. It is also in the House Economic Development, Banking and Insurance Committee.

I am sure that the second half of the 138th General Assembly will be much more

Public Laws and Legislative Actions Committees



The Medical Society of Delaware's banner hung in the Hotel DuPont as over 250 physicians, spouses and vendors passed under to attend the Annual Meeting.

active, and I look forward to working with my two committees and the Board of Trustees of the Medical Society of Delaware to accomplish our goals.

I would also like to report that I have been attending fund-raisers for legislators and other electable officials who are friendly to medicine. Along with the hierarchy of the Society, I have attended several meetings with State Senators and Representatives from all three counties to inform them of the key legislative issues that we are going to champion during the first six months of 1996.

Once more, I want to thank the Executive Director and Associate Executive Director of the State Medical Society, Mr. Mark Meister and Ms. Beverly Dieffenbach, for their tremendous help in setting up the meetings of these two important committees and coordinating with me their tasks and trips to Legislative Hall.

Finally, I want to thank all the members of these two committees for their indefatigable dedication and contributions. This makes it possible for us to review every piece of legislation that is even remotely related to medicine that is introduced in either chamber of the General Assembly by either party. Their cooperation in working through the bills that we specifically have had a part in drafting and writing is also greatly appreciated.

Last but not least, I would like to express my gratitude to Phil Corrozi, who has lent his experience in Legislative Hall

to make our work more gratifying.

Jorge A. Pereira-Ogan MD
Chair

The report was filed with commendation to Dr. Pereira-Ogan and with a request to the membership to serve as volunteers for the Doctor of the Day program at Legislative Hall.

Publication and Editorial Committee

Thanks to the hard work and talents of the MSD staff (largely Heidi Norman) we have continued uninterrupted publication of our *Delaware Medical Journal*. The continuing decrease in national advertising — largely pharmaceutical companies — has forced some state medical journals to discontinue publication or go to a quarterly pattern. So far *DMJ* has been able to survive on local advertising, though rising costs of printing, postage and other items have caused increasing cost overruns. Although technically the cost of the *Journal* to our members remains \$10 out of our dues each year, the absorption of the deficit by the Medical Society of Delaware each year makes the actual cost closer to \$20 per year.

These financial considerations and other matters were discussed at the May meeting of the Publication and Editorial Committee, and as a result we are having discussions with Suburban Marketing Associates (publishers of *Dela-*

Publication and Editorial Committee

ware Today) and one other publisher relative to their taking over certain aspects of our publication. We are taking care to preserve the autonomy and integrity of what goes out under our name.

E. Wayne Martz MD
Chairman

The report was filed with commendation to Dr. Martz for all his hard work.

Report of the Nominating Committee

A meeting of the Nominating Committee was held in Dover on October 4, 1995, to consider positions to be filled by the House of Delegates at its meeting on November 17, 1995. The following nominations were made:

President	Carol A. Tavani MD
President-Elect	Paul E. Howard MD
Vice President	Stephen S. Grubbs MD
Secretary	Martin G. Begley MD
Treasurer	Garth A. Koniver MD
Speaker of the House	Roger B. Thomas, Jr. MD
Vice Speaker of the House	Leslie W. Whitney MD
Representative to the Delaware Academy of Medicine	Anthony L. Cucuzzella MD
Delegate, American Medical Association	Stephen R. Permut MD (two-year term to expire 12/31/97)
Delegate, AMA	Robert G. Altschuler MD (two-year term to expire 12/31/97)
Alternate Delegate, AMA	Alfonso P. Ciarlo MD (two-year term to expire 12/31/97)
Alternate Delegate, AMA	Rafael A. Zaragoza MD (two-year term to expire 12/31/97)

Judicial Council

Edgar R. Miller MD
(three-year term to expire 11/98)

Elected Committees:

Budget and Finance Committee

(one year terms)
Anthony L. Cucuzzella MD
William H. Duncan MD
Gertrude Findley-Christian MD
John J. DiBonaventure DO
Stephen S. Grubbs MD
Joseph E. Hacker III MD
Ali Z. Hameli MD
Garth A. Koniver MD
E. Wayne Martz MD
Thomas J. Maxwell MD
William L. Medford, Jr. MD
Janice E. Tildon-Burton MD
Thomas S. Vates MD

Committee on Ethics

Mehdi Balakhani MD
Rhoslyn J. Bishoff MD
Judge William C. Bradley
Garrett H. C. Colmorgen MD
Daniel L. DePietropaolo MD
Honorable Joseph G. Di Pinto
Paul T. Durbin Ph.D.
John J. Egan MD
Beth N. Fisher DO
Robert W. Frelick MD
John J. Goodill MD
Michael J. Guarino MD
Robert E. Heckman MD
Dennis J. Hoelzer MD
William L. Jaffee MD
Robert G. Kettrick MD
Maurice Liebesman MD
Ananth P. Nabha MD
William R. Nottingham, Jr. MD
Stephen R. Permut MD
Edward F. Quinn III MD
Harold S. Rafal MD
Rev. Judy Zingaro

Board of Directors Medical Society of Delaware Insurance Services:

Report of the Nominating Committee

Elected Committees



The Alliance learns "More Secrets from the Hotel DuPont's Kitchen."



One of the benefits of the Annual Meeting is the complimentary blood work provided by Medlab and LabCorp. Dr. Dworkin had his blood drawn early Saturday morning.

Resolutions

(one-year terms)

Robert G. Altschuler MD
Thomas W. Fiss, Jr. MD
Stephen S. Grubbs MD
Joseph F. Kestner, Jr. MD
James P. Marvel, Jr. MD
Thomas J. Maxwell MD
Mr. Mark A. Meister
Joseph F. Rubacky III, DO
Rafael Z. Zaragoza MD
William H. Duncan MD,
Emeritus Director

Board of Directors, Delaware Foundation for Medical Services

(three-year terms to expire 12/
31/98)

William Ellert MD
James P. Marvel, Jr. MD
Stephen R. Permut MD

Nominees for Board of Medical Practice (three-year terms)

Sussex County

Roger S. Alexander MD
Jose L. Barriocanal MD
Eduardo L. Jiloca MD
Richard H. Sherman MD
Frederick K. Toy MD

New Castle County

Michael A. Alexander MD
James E. D'Amour MD
Andrew J. Doorey MD
Raymond R. Noble MD

New Castle County

Raafat Abdel-Misih MD
Barry S. Denenberg MD
Albert A. Rizzo MD
John S. Wills MD

Respectfully submitted,
Carol A. Tavani MD, Chairman
Joseph F. Kestner, Jr. MD
Joseph F. Rubacky DO
Richard H. Sherman MD

Stephen F. Wetherill MD

The report of the Nominating Committee was adopted by the House of Delegates.

Resolutions

RESOLUTION 95-1, Unified Membership — American Medical Association Introduced by the House of Delegates

Whereas, on November 15, 1985, the House of Delegates, after lengthy debate, adopted Substitute Resolution 85-9 calling for the Medical Society of Delaware to adopt a unified membership policy and to require that membership in the American Medical Association or the American Osteopathic Association be mandatory for all Medical Society of Delaware members; and

Whereas, the resolution noted that the American Medical Association is the logical organization that cuts across all local and specialty societies to speak for organized medicine and that the AMA increases its political "clout" in direct proportion to its number of members and financial ability;

Whereas, the House of Delegates on November 14, 1986, adopted the recommendation of the Bylaws Committee that the Bylaws of the Medical Society of Delaware be amended to implement a policy of unified membership beginning with the 1987 dues year; and

Whereas, Article III, Membership, Section 1, of the current Bylaws of the Medical Society of Delaware states that

"Membership in the American Medical Association or the American Osteopathic Association is mandatory for all Medical Society of Delaware members"; and

Whereas, benefits accruing as a result of unification include additional delegate representation in the AMA's House of Delegates, a 10 percent discount on AMA dues for 1st-year-in-practice, 2nd-year-in-practice, military, and full dues-paying members, and services of AMA staff for special projects for the Society; and

Whereas, the issue of unified membership has on occasion been raised by members as well as non-members of the Medical Society of Delaware; and

Whereas, the House of Delegates at its annual session on November 20, 1992, reaffirmed its support for a unified membership policy; and

Whereas, the House of Delegates at its annual session on November 20, 1992, resolved that the unified membership policy be reaffirmed by the House of Delegates at its 1995 Annual Meeting and every three years thereafter as long as the policy is in force; now therefore be it

Resolved, that the House of Delegates at its annual session on November 17, 1995, reaffirm the unified membership policy of the Medical Society of Delaware.

The reference committee recommended that this resolution be adopted. Resolution 95-1 was adopted

by the House of Delegates.

RESOLUTION 95-2, AMA Emeritus Delegate Introduced by Board of Trustees, Medical Society of Delaware

Whereas, I. Favel Chavin MD, has been a long-standing active member of MSD including being a past president of the MSD; and

Whereas, Dr. Chavin has been a long-standing delegate to the AMA House of Delegates from the State of Delaware; and

Whereas, Dr. Chavin recently resigned his position as chair and senior delegate for Delaware to the AMA House of Delegates; and

Whereas, there exists no such official status within the AMA as "Delegate Emeritus"; and

Whereas, Delaware frequently cannot field a full delegation (three delegates and three alternate delegates) to the AMA House of Delegates; and

Whereas, it is appropriate for Delaware to establish such a position (Delegate Emeritus) which would allow Dr. Chavin to be seated as an alternate delegate when one of our elected delegates or alternates cannot attend an AMA House of Delegates meeting; now therefore be it

Resolved, that Dr. I. Favel Chavin be named an Emeritus Delegate from the State of Delaware to the AMA House of Delegates.

The Reference Committee recommended that this resolution be adopted.



Mrs. Bradley, Dr. Bradley, Dr. Foster and Governor Carper gather at the luncheon.



Dr. Henry W. Foster MD presented a speech to a full house at the Annual Luncheon.

Resolution 95-2 was adopted by the House of Delegates.

RESOLUTION 95-3, Recognition of MSDIS Board of Directors

Introduced by Board of Trustees, Medical Society of Delaware (MSD)

Whereas, the Medical Society of Delaware created a fully owned subsidiary corporation, Medical Society of Delaware Insurance Services, Inc. (MSDIS), in 1983 for the purpose of assuring the availability and affordability of medical liability insurance for Delaware physicians; and

Whereas, MSDIS has not only successfully for over 10 years met fully the letter and the spirit of its purpose, but with initiative and foresight in the ever-changing environment of health care, was instrumental in creating joint ventures with the Zutzy/PLI Insurance Agency and RTA Financial Services, Inc., thereby providing all lines of insurance for Delaware Physicians; and

Whereas, these joint ventures have significantly enhanced the value of this service to the Medical Society; and

Whereas, MSDIS has set a goal to insure all eligible Delaware physicians with those insurance products for which there is a need; and

Whereas, the initial response to all these efforts by the members of the Society has been worthy of recognition by the House of Delegates since all dividends from these efforts accrue directly to the Society; now therefore be it

Resolved, that the House of Delegates extends its utmost thanks and appreciation to the members of the Board of Directors of the Medical Society of Delaware Insurance Services, Inc., for their dedication and service.

The Reference Committee recommended that this resolution be adopted, as all members of the Reference Committee recognize the importance of MSDIS to the members of this Society for both insurance services and financial support. Resolution 95-3 was adopted by the House of Delegates.

RESOLUTION 95-4, Charitable Services Committee Introduced by John M. Levinson MD

Whereas, in 1991 after four years of intensive efforts, the Medical Society of Delaware was able to formally begin delivering charitable health services to the needy at the Claymont Community Center (CCC); and

Whereas, the Charitable Services Committee in its first two years worked very hard to implement these goals and attempted to broaden our role in our state; and

Whereas, through the efforts of the Medical Society of Delaware and the Charitable Services Committee:

- Approximately 100 physicians provided volunteer gratis care.
- Significant volunteer aid was mobilized from various health workers, elected officials and others.

- Major funding was obtained for the CCC Clinic.
- Major donations of equipment and medicines were provided; and

Whereas, significant efforts were being made up to three years ago to:

- Follow our mandate to introduce additional clinics in Delaware, work with the Homeless Project and study other efforts to provide charitable care.
- Introduce a "work-fare" or "health-fare" concept at the CCC. That is, it was hoped that those receiving charitable services might perform volunteer work at the Claymont Community Center in lieu of financial payment for medical services. This might afford a measure of self-esteem to the patients and offset the monies available to run the CCC; and

Whereas, over the past three years, there is only record of the Charitable Services Committee having met on two occasions, in 1993; and

Whereas, there is no firm information on the status of projects, old or new, in the committee report in the past three years; now therefore be it

Resolved, that the Medical Society of Delaware reorganize this committee and further define and/or re-define its responsibilities. Failing this, the committee should be disbanded, as its current status is without value.

The Reference Committee recommended that the sponsor of this resolution be

permitted to withdraw this resolution as per his request. The House of Delegates voted to permit withdrawal of Resolution 95-4.

RESOLUTION 95-5 (Late Resolution), Medicare Conversion Factor

Introduced by Michael J. Bradley DO, Rafael A. Zaragoza MD, President, Delaware Chapter, American College of Surgeons

Whereas, the Medicare Trust Fund will go bankrupt in the year 2002; and

Whereas, the United States Congress under the Republican leadership has come up with a plan to transform the Medicare System; and

Whereas, the AMA has been working with the Republican Congress and has negotiated a compromise proposal in the United States House of Representatives; and

Whereas, the compromise has many physician-friendly proposals, such as a cap on non-economic damages, repeal of CLIA, anti-trust reform, overhaul of Stark I and II, creation of medical savings accounts; and

Whereas, the proposal has recommended a single conversion factor for Medicare services for all physicians; and

Whereas, this single conversion factor over the long run will be beneficial for all physicians; and

Whereas, the surgical specialists will bear the largest and most dramatic cut in their MVPS current conversion; and

Whereas, unless there is a



Dr. Bradley addressed the House of Delegates assembled at the Delaware Academy of Medicine.



Angelo Troisi of the Maryland Medical Society presented Dr. Bradley with a gift from Maryland to MSD.

change in the current MVPS, all physicians' conversion factors will decrease dramatically over the next few years; and now therefore be it

Resolved, that the Medical Society of Delaware should oppose the immediate reduction of the conversion factor in favor of a gradual change; and be it further

Resolved, that the Medical Society of Delaware notify Senator Biden, Senator Roth and Representative Castle of this recommendation; and be it further

Resolved, that the Medical Society of Delaware urge the AMA to continue to negotiate with the Congress towards this gradual change.

Resolution 95-5 was received within 21 days prior to the House of Delegates and was therefore a late resolution. The Bylaws of the Medical Society of Delaware state that resolutions received within the 21 days prior to the House of Delegates meeting shall be referred by the Speaker to an appropriate reference committee, which shall decide whether or not the resolution shall be presented to the House. Favorable action on such a resolution requires the affirmative vote of three quarters of all delegates present and voting.

The Reference Committee recommended that Resolution 95-5 be presented to the House. The Reference Committee also recommended the following substitute for the first Resolved.

Resolved, that the Medical Society of Delaware oppose any reduction in conversion factors, but that if any reduction should take place, that change should be gradual; and be it further

Resolution 95-5 as amended by the above substitute

Resolved was adopted by the House of Delegates.

RESOLUTION 95-6 (Late Resolution), Managed Care Introduced by Roger B. Rodrigue MD, Stephanie Malleus MD

Whereas, Managed Care captures more patients each year and limits services for patient care management by screening and authorization procedures which in some instances impede the best patient care; and

Whereas, reimbursement for physician services continues to be reduced with physician reluctance to see patients and adverse health care consequences result, while premiums paid by patients contribute more to management and bonuses and insurance company profits; now therefore be it

Resolved, that the Medical Society of Delaware recommend to the Administration of the U.S. Government that caps be placed on the premium percentage to be used for administration and bonuses and profit to insurance companies and that fair and equitable amounts be allocated to patient care from premiums collected.

The Reference Committee recommended that Resolution 95-6 be presented to the House for consideration. The Reference Committee, which expressed support for the concept of the resolution, also submitted the following Substitute Resolution.

**SUBSTITUTE
RESOLUTION 95-6**

Whereas, Managed Care captures more patients each year, and limits services for patient care management by screening and authorization

procedures which in some instances impede the best patient care; and

Whereas, reimbursement for physician services continues to be reduced while premiums paid by patients contribute more to management costs and bonuses as well as insurance company profits; now therefore be it

Resolved, that the Medical Society of Delaware recommend to the Insurance Commissioner of the State of Delaware that full disclosure be required by all Managed Care Companies concerning the premium percentage to be used for administration and bonuses and profit to insurance companies and show that appropriate amounts are being allocated to patient care from premiums collected; and be it further

Resolved that publicity be provided to all businesses in the State requesting them to consider these disclosures in determining their health care coverage.

A motion in support of reaffirmation of the Society's current policy of support for the Patient Protection Act (voted on last year by the House of Delegates) was adopted.

RESOLUTION 95-7 (Late Resolution)

Whereas, Leonard P. Lang MD, who provided the report from the Delaware Academy of Medicine, has recently passed away; and

Whereas, Dr. Lang was the "Dean" of academic internal medicine in the state of Delaware; and

Whereas, Dr. Lang devoted the majority of his professional life to providing the highest level of education to medical students, residents, and staff physicians; and

Whereas, Dr. Lang always approached students, residents, colleagues, and patients in the manner of a consummate clinician and gentleman; and

Whereas, Dr. Lang was always an advocate and ambassador for the profession of medicine and the specialty of medicine; now therefore be it

Resolved, that the Medical Society of Delaware hereby express its condolences, appreciation, and commendation to Dr. Lang's wife and family for his lifetime of service to the Delaware medical community. **The Reference Committee recommended that this resolution be presented to the House of Delegates. Resolution 95-7 was adopted by the House of Delegates.**

The remainder of the reports considered at the House of Delegates meeting will be published in the February 1996 issue of the Delaware Medical Journal.

The complete report of the Proceedings of the 1995 House of Delegates is on file at the Medical Society office and is available to members.



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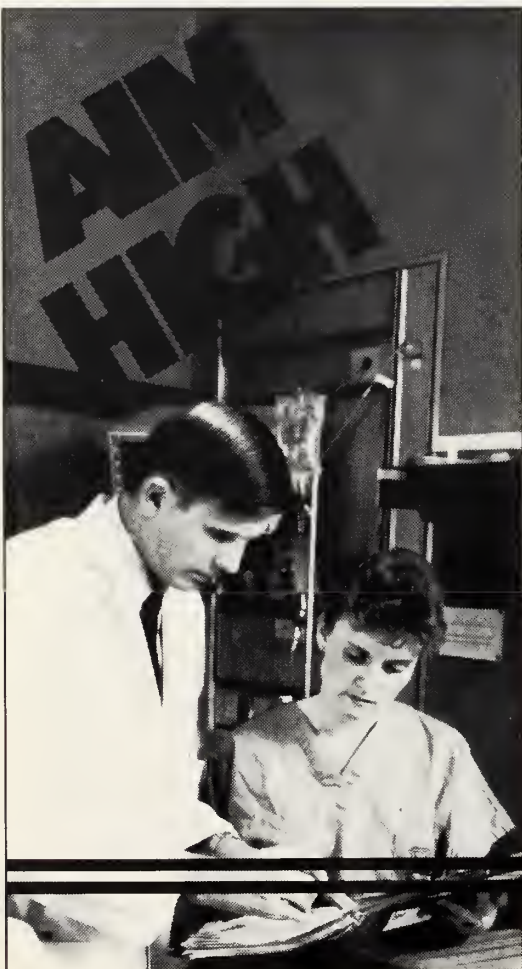
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LETTER TO THE EDITOR

A couple of months ago I received an interesting document on "Street Drug Use In Delaware." I sent it to selected members of our Editorial Board for review, and all who read it (three) said essentially, "This is not science. There are no references, and it should not be published as a scientific article." However, all agreed it was interesting and informative. I have shortened it considerably and elected to publish it as a Letter to the Editor, but in two parts. It is an opinion, a view point, an anecdotal overview of a complex problem written by someone who seems thoroughly familiar with his subject. For your interest and enlightenment, here it is. — EWM

Street Drug Use in Delaware

Mario Pazzaglini PhD

Since 1967, we have been researching the use of street drugs in Delaware and the relationship of this use to street drug use throughout the United States. Data for this study have been accumulated from two sources: information gathered within the context of drug and alcohol treatment services in Delaware and elsewhere (California, New York, Boston, Washington DC, Baltimore, Miami, Latin America, Asia, Europe, Canada), and from street interviews with actual drug users and dealers in the same locations. People from a wide range of socioeconomic and ethnic groups have been evaluated, in schools, on the street, in neighborhoods, and in industry. The basic and most obvious finding of our endeavor is that much of Delaware's population is and has been profoundly involved in the use and abuse of street drugs.

A summary of current changes in patterns of drug abuse:

- 1) Increase in availability of street drugs, especially cocaine, LSD and tranquilizers;
- 2) Regression to use of alcohol when street drug supply diminishes;
- 3) Use of multiple drugs to produce complex effects;
- 4) Poor quality of street drugs, especially marijuana mixtures containing additives like PCP, insecticides and/or jimson weed;
- 5) Loss of specificity in use of street drugs; users desire to "get different" instead of desiring a specific kind of high. LSD, heroin and cocaine users may be exceptions to this. LSD use is currently on the rise;
- 6) Wider range of ages using drugs, especially young (7 to 12) age groups. This also includes the use of this group as drug "runners";
- 7) Increasing use of drugs in pseudo-religious rituals. These are usually younger people with no real idea of what they are doing. (Some cultural groups use specific drugs in a religious context, e.g., mescaline. These are excluded in the above observation.);
- 8) Devices (electronic) are being developed that cause altered perception and altered states of consciousness at times leading to hallucinatory experiences. These are sold

- and advertised in magazines and are available over the counter in major cities.
- 9) Much drug taking is beginning to be seen as a cultural norm. A "normal" adolescent may engage in some street use and this is considered "normal experimentation." Whether "good or bad" this is clearly a developing cultural issue;
 - 10) Increase in use of "street medications" is noted;
 - 11) The new category of "street-sold poisons" is noted;
 - 12) Islands of nondrug use (both geographic and social group) are appearing in major cities. Whether this is a stable phenomenon or not is unknown at this time. At times this may be accompanied by membership in an organized club or "cult."
 - 13) Recently there have been pockets of young teenagers substituting high-risk behavior (especially shoplifting) for drug use but then regressing into drug and alcohol use again. This points out the connection between various kinds of peer-generated risk taking and drug and alcohol abuse.
 - 14) "Invisibility" of drug users: most middle to upper class drug users do not fit normal stereotypes of drug users. They may look "clean cut."

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IN BRIEF

CME Opportunities

California

77th Annual Session of the American College of Physicians will be held April 25-28, 1996 in San Francisco, California, at the Moscone Convention Center. The theme will be "Changing Perspectives, Promoting Quality" and there will be 300+ courses with four educational tracks (Clinical Skills, Recertification, the Practice Environment, Computers in Medical Practice). For more information, call the annual session hotline at (800) 523-1546, ext 2600.

Virginia

The Annual Meeting of the Virginia Society of Ophthalmology will be held May 16-18, 1996, at the Waterside Marriott, Norfolk, Virginia. Topics presented will include: radial keratotomy, automated visual fields, and managed care. For more information contact Donna Scott, PO Box 23027, Richmond VA, 23223. Or call (804) 649-2407.

HMOs Ordered to Pass Along Negotiated Discounts

As reported in the *Maryland Medical Journal* (December 1995), "New Hampshire's insurance department will require that HMOs pass on discounts negotiated with providers to consumers and calculate patient copayments based on the discounted rather than the retail price. Healthsource, New Hampshire's second largest HMO, recently began passing along discounts to subscribers, and Blue Cross Blue Shield agreed to begin passing on discounts under its point of service plan last spring.

In August, a federal court in Ohio ruled that Blue Cross and Blue Shield of Ohio misled policyholders by not disclosing price discounts negotiated with providers and that the company breached its fiduciary duties under the Employee Retirement Income Security Act (ERISA)."

Jefferson Medical College Dean Appointed to Chair Medical School Accrediting Body

Joseph S. Gonnella MD, senior vice president for Academic Affairs and dean of Jefferson Medical College, has been appointed chair of the Liaison Committee on Medical Education (LCME) through December 1997.

The LCME is the accrediting body sponsored jointly by the American Medical Association and the Association of American Medical Colleges. It is responsible for all medical education programs offering doctor of medicine degrees in the United States and Canada. It also encourages accredited institutions to include graduate and continuing physician education, allied health education, graduate education in biomedical sciences, public health and research.

In his role at Jefferson Medical College, Dr. Gonnella is responsible for the development and management of administrative affairs and academic programs in education, research and patient care.

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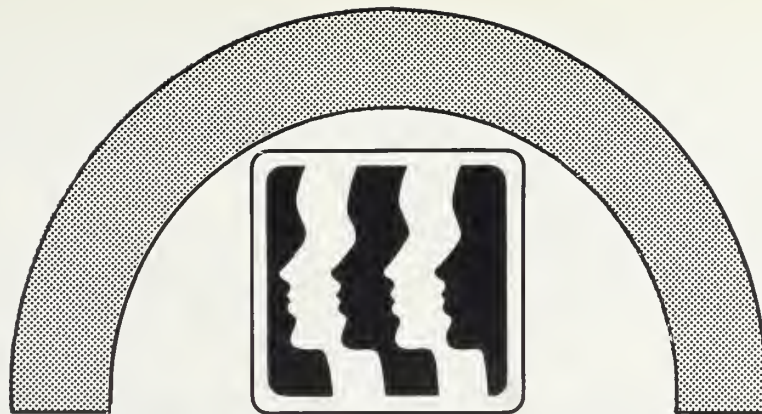
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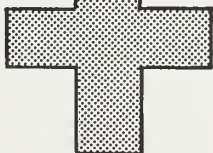
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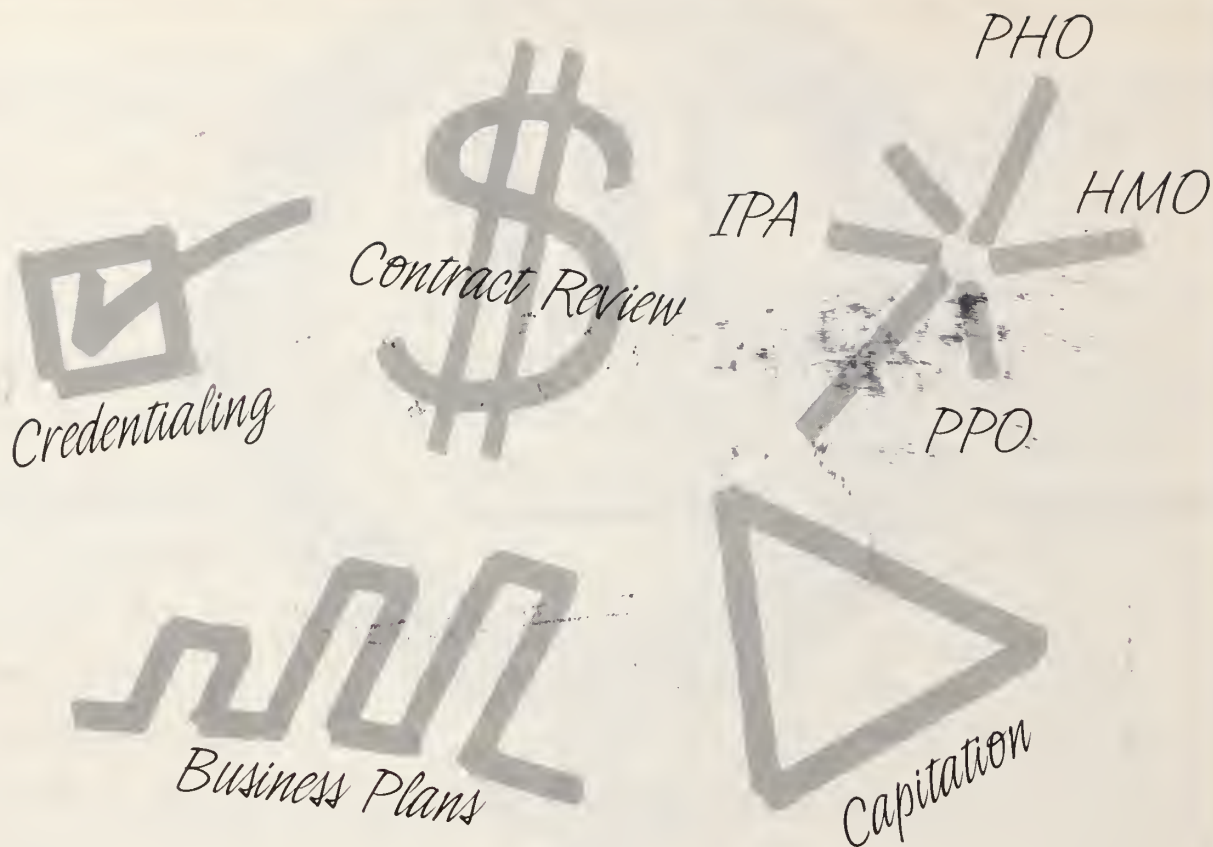
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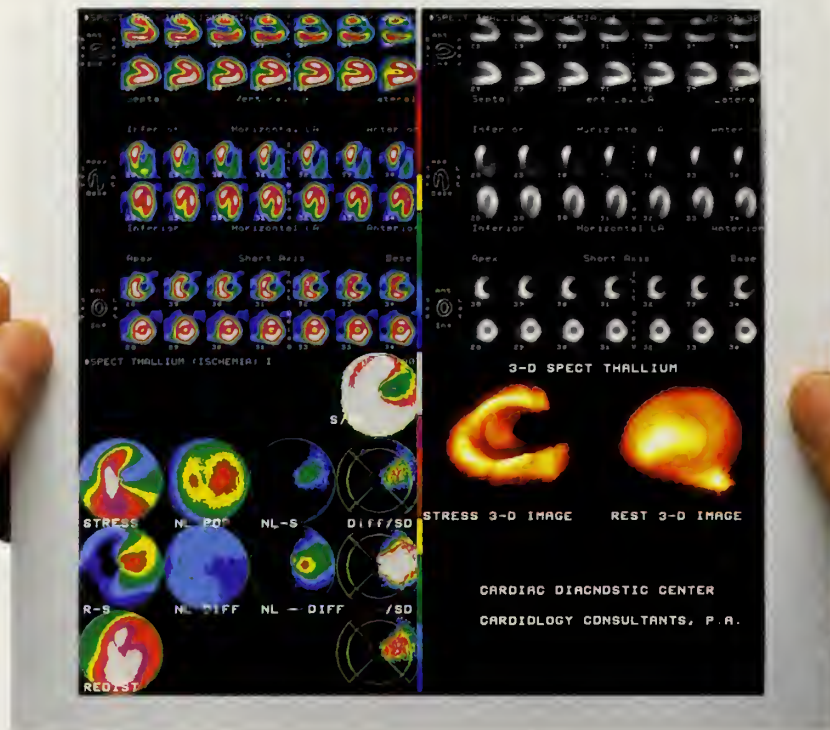
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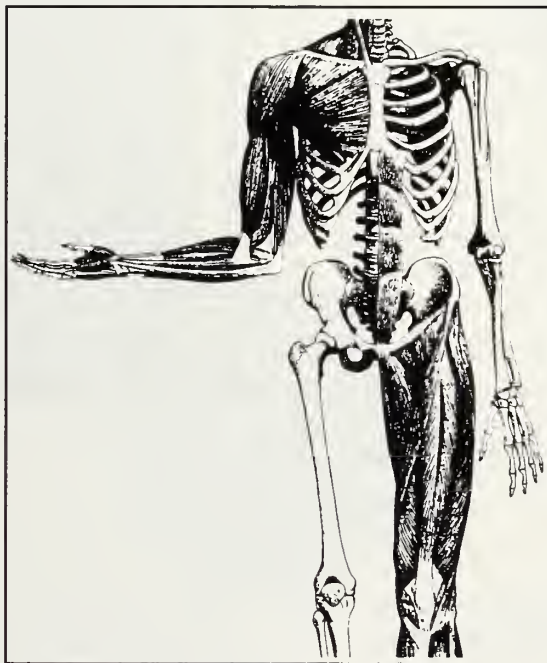
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A Bold New Service

In its final meeting of 1995, the Board of Trustees voted to allocate Society resources to an exciting project which will be of considerable benefit not only to the entire physician community, but also to Delaware's hospitals and other health care organizations. The project is the creation of the Centralized Credentials Verification Service of the Medical Society of Delaware. A business plan has been crafted and approved, and the project is underway.

Here's how it works: In order to practice medicine within the structure of any organization, a physician must complete a lengthy application and provide documents attesting to state licensure, Drug Enforcement Agency Certificate, hospital clinical privileges, Board certification, malpractice liability coverage, medical education, malpractice case experience, and Medicare/Medicaid eligibility. When the application and the documents are received, the organization (hospital, HMO, PHO, third-party payor, etc.) must then perform what is called *primary verification*; this consists of the checking of all credentialing documents with the original source of the credentials. As is the case in most states, Delaware's physicians must complete a separate application for each health care organization with which one is affiliated, even though the information requested is essentially identical — and, in turn, each of numerous organizations must perform primary verification on a largely overlapping set of physicians.

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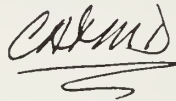
one single, standard application, which is entered into a central, computerized data base. This information is then verified, and, under the direction of the physician, is released to the health care organizations the physician designates, assuming those organizations participate in the service (in the case of organizations which may choose not to participate in the service, a completed document using that organization's form will be generated; it is expected that these cases will be few in number). It should be noted that the Medical Society's Service makes no credentialing decisions for any organizations; it provides them with the primary verification information on which decisions for inclusion are predicated.

In addition to the above, the service will eventually (likely in its second year of operation) centralize the surveying of physician practice sites; at present, each managed care organization visits the physician's office separately, reviewing the same sort of information, in accordance with standards established by the National Committee for Quality Assurance (NCQA). The service, however, will be able to visit the office once yearly, then share the review with the organizations the physician designates. The service will apply for NCQA accreditation to perform this function once it has been operational for six months.

The service will be offered to all Delaware physicians, whether or not they are Medical Society members. The advantages of the system are obvious, and include: 1) a drastic

reduction in the duplication of effort and redundancy of paperwork presently inevitable; in the present environment, this can amount to as much as 100 annual hours of clerical time in an individual physician's practice; 2) increased efficiency in timeliness and reliability; and 3) a "win-win" situation, wherein physicians and health care organizations realize cost savings, diminution in hassle-factor, and the achievement of a collaborative mode in an otherwise potentially competitive or even adversarial situation.

The Medical Society is uniquely poised to perform this important function, and having it housed therein ensures critical physician input, which has all too often been excluded in such endeavors. I am proud to be president of the Society at a time when such physician-friendly activities, which make burdens more bearable and life more pleasant, are taking place.



Carol A. Tavani MD

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Why Is Health Care Reform Faltering? Delaware's Experience

Robert W. Frelick MD

Introduction

This review is based on personal involvement in many of the efforts to improve health care in Delaware over the last 48 years. It seeks to help others understand why reform is needed, and concludes with suggestions for achieving some limited, but feasible steps, to assure health services for most Delawareans.

History

The late forties predicted the millennium in health care by way of miracle drugs such as penicillin, improved anesthesia for complex surgery, new diagnostic x-ray and laboratory equipment which could detect early stages of diseases, and indemnity payments for most hospital care by Blue Cross/Blue Shield.

During the fifties, advances in infection control, cancer chemotherapy, and radical cancer surgery fueled a prediction that the "cancer problem" would be resolved in five years. The public was sold on the inevitable control of the then-fatal disease.

In the early sixties, General Motors signed a contract with the United Auto Workers and sent National Vice Presidents to Wilmington with their Blue Cross counterparts to ask local physicians to accept full service contracts for hospital care instead of indemnity contracts. Health benefits were considered a business expense and a way to increase workers' income since such benefits were not taxed. The local physicians were

finally, but reluctantly, persuaded that usual, customary and reasonable charges could control costs. It was also during this time that the national regional medical programs for heart, stroke and cancer were introduced. Delaware at first belonged to the Greater Delaware Valley Program, but later developed its own program, and finally withdrew because federal demands required an overhead out of proportion to the program's benefits.^{1,2}

During the same decade (1960s), the three non-sectarian hospitals in Wilmington merged, providing expanded resources for an educational program which attracted many residents and competent physicians to the state. A voluntary Health Planning Council³ monitored and controlled beds and expansion of health care facilities; it initiated a health planning process for Delaware.⁴ The state agreed to subsidize 20 places at Jefferson Medical School for Delaware students in lieu of a state medical school.

The early seventies, after the federal freeze of fees, presented a "use it or lose it" situation for physicians when an annual opportunity was provided to raise their fees in order to meet rising overhead from inflation, and for the use of more sophisticated and complicated equipment. Federal aid triggered hospital building and excess bed capacity while indigent care became too expensive for private charity. Big business found it could save on health care costs by self-insuring, thus avoiding community rating for health insurance which covered all,

Dr. Frelick, as a physician, has been actively involved in health care in Delaware for almost 50 years.

including those with poor health. Self-insurance was subsequently protected from state regulation by the federal ERISA Amendment. This also allowed an employer to use one health package across many states. Employees not covered often found it impossible to pay for premiums as individuals, and small businesses found an escape by using hourly part-time workers who were not organized to gain health insurance benefits.

In the eighties, an urban citizen's group filed a "civil rights" lawsuit which cost the community about \$50 million because it caused a five-year delay in the building of a large hospital in the county to replace two of the three buildings in Wilmington. Delaware's physician-managed, peer-review system, which was exerting some control over fees, had to be discontinued after anti-trust actions were threatened because the Medical Society had urged its members to keep fees down.

Studies and Plans

In 1977 a private foundation study in Delaware by Dr. Ellwood,⁵ (who later became well known through the Clinton Health Care Plan) recommended managed care through Alliances. A health plan for '79-84^{6,7} belittled many of Delaware's problems because they were worse in surrounding states. It noted an increasing demand for expensive technological care without concern for costs, because of "good" health insurance. The recommendations of that health plan included: preventive measures, Certificate of Need (CON) legislation, activation of a Professional Standards Review Organization (PSRO), exploring the feasibility of Health Maintenance Organizations (HMOs), and educating the public and health providers about the costs of health care. A paper in *Science* echoed those feelings.⁸ A Duke University meeting of national health care experts strongly urged *rationing* to control costs.⁹ A 1984 University of Delaware study¹⁰ of health care costs critiqued competition as a proposed solution. It recommended a Governor's Commission on Health Care Cost Management, which was duly appointed. In 1987 the Commission reported¹¹

on many defects in the health care system. None of these early studies to control costs referred to the Employee Retirement Income Security Act (ERISA).

Government regulations to control costs, such as the Diagnostic Related Groups (DRGs), became a bonanza for many hospitals, and certificates-of-need (CON) often failed to control overall costs. While a CON could restrict a hospital's purchase of expensive equipment, physicians could buy and operate such equipment outside the hospital.

Patients without health care insurance had reduced access to early care, which often resulted in more complicated and expensive health problems. Emergency rooms with full-time specialized physicians provided primary care for the underinsured. Simple colds could easily cost 10 times an office charge. To cover the extra costs of the uninsured, health care providers charged more to those with insurance, and as a result, health insurance premiums rose, forcing more and more to join the ranks of the underinsured.

The federal and state Medicaid patients were not popular with primary care physicians because Medicaid fees barely covered office overhead. Because of the absence of payments for indigent care, and because about 40 percent of hospital in-patients were Medicare or Medicaid and their discounting of payments was mandated by the Health Care Financing Administration (HCFA), \$.67 was added to each dollar of charges for the other paying patients at the Medical Center of Delaware, the largest hospital and tertiary care center in the state. At the same time expenses went up for advances in radiotherapy, Magnetic Resonance Imaging (MRIs), and for new drugs because of the extra costs to gain Food and Drug Administration (FDA) approval. Access became more and more of a problem for those unable to afford insurance.

In 1990, the Delaware Indigent Health Care Task Force¹² noted that 84 percent of the medically indigent were working full time without employer-provided health benefits. It proposed a Health Care Commission (HCC) to: expand primary care; improve the Medic-

aid program; emphasize *prevention*; reform health insurance; and support pilot projects for the delivery of services to the underinsured. They recognized that hospitals needed protection from "inappropriate financial burdens" to prevent costs from becoming a disincentive for services. Cigarette taxes were suggested to finance the recommendations.

The Implication of Increased Health Care Costs

Inflation and advances in technology share blame with government requirements and regulations for health care costs that now consume about 15 percent of the nation's gross national product. Those costs also undermine industry's ability to compete in the world market place. Yet, 17 percent of Americans remain uninsured, and U.S. health statistics are worse than those in most industrialized countries. Employees with employer-paid health benefits are reluctant to risk changes in a system where they are vaguely comfortable, and whose advantages they want for themselves. Therefore, the "push" for reform came chiefly from employers and from the government as both felt the financial "pinch" of rising health care costs.

It was in this context that the Clinton Health Plan was proposed. Local citizens' groups (such as the Alliance for Health Care, and a Public Policy Group), sponsored several well-attended forums and workshops for the public to help them understand and explore options for health care reform. The Medical Society published principles for health care reform, modified slightly by the Hospital Association. Clinton's proposals to make employers finance health care reform caused big business to retreat from all reform plans. Subsequently third-party insurers, physician groups, and hospitals began competitively to sell managed care plans to industry, Medicaid and Medicare. Health care providers caught between such competing groups often signed up with several groups in hope of maintaining a patient base. Patients caught between competing managed care plans have been and are upset by restricted choices of

physicians and by the confusing red tape. Hospitals, whose bed use is being rapidly reduced by shorter stays and more outpatient care, are trying to compete through HPOs (Hospital Physician Organizations) and integrated care programs.

Most of the competing market systems, as well as the various national plans, have accepted the concept of preventive care without adequately financing it. They have also avoided the support of public health, clinical research, education of health providers, and the care of the medically indigent. *No one is competing to care for the poor.* All of the competing "plans" as well as the state planning groups have ignored ERISA, which allows business to self-insure a basically healthy workforce and thus avoid state regulations which "*level the playing field*" through community rating. The for-profit insurers have piled on administrative costs for patients and doctors, made money hand-over-fist, paid CEOs outrageous salaries, and then blamed providers for escalating costs.

Draconian cuts are now being proposed in Medicare and Medicaid to balance the federal budget, while the public is told that managed care will assure the availability of quality health care. In contrast, by maintaining *community rating* with a waiver from ERISA, Hawaii is able to provide the best access to affordable health care in the United States.

Delaware's lay-led Health Care Commission, which commissioned a study¹³ of affordable health insurance for small businesses through group purchasing, now seems to appreciate the need for community rating in order to make its proposal feasible. The State Department of Health and Social Services has recently obtained a HCFA waiver to put its Medicaid population into managed care, and hopes to save enough to support other underinsured people. Consultants have told the HCC that since they could not possibly measure the indirect financial impact of malpractice suits, they would not recommend any changes in the malpractice system. The HCC was also told that ERISA, which insulated self-insuring employers from state regulation, has eliminated an estimated 70

percent of Delaware's insured workforce from any state-mandated reforms. The Commission has heard that a single-payer system could provide universal access for less money than is now being spent by the government and the private sector. A savings of 15 to 20 percent was projected largely through a drop in administrative costs. In that system, by taxing self-insurers the same as everyone else, ERISA would be by-passed, since employers would not want to pay for self-insurance plus the taxes. A single payer system would also allow patients a choice of physicians. However, both the general public and legislators are opposed to any more taxes and to government interventions, even though the taxes should be lower than current insurance premiums.

Discussion

Using the competitive marketplace to resolve health care access and costs is proceeding full force in the U.S. and in other countries, such as New Zealand, which has long had a government-run system.¹⁴ Their physicians' concerns mimic those held by U.S. physicians who wonder how competition will stimulate physician collaboration to address common problems, support public health, prevention, professional education and research as well as providing for the poor.

The medical literature was reviewed¹⁴ to determine whether patients were harmed by the loss of continuity of care by employers who "forced" patients into managed care programs in order to obtain coverage, and then might compound the loss of continuity by shuttling employees to different managed care organizations with less expensive health insurance. A few well-controlled studies have affirmed the value of continuity of care for the short term, but no studies could be found which looked at the value of long-term continuity of care. In addition, no articles demonstrated overall improved quality of care or any fiscal advantages with "gatekeeper" managed care in a general population over a period of years.

A list of multiple studies and reports¹⁵ over the last 15 years (available upon re-

quest) is convincing evidence that Delaware has had more than enough studies, and now should implement certain recommendations to improve health services.

Summary

Many managed care plans propose short-term economics, without stressing quality, assuring universal access, supporting research, or caring for the poor. None provide much in the way of preventive services. In the absence of any major national changes to assure universal access to health services, local health care providers and state regulatory agencies need to be freed from many restrictive federal laws and regulations. Relief is needed from well-intended federal controls which have usually made the health care system more expensive 1) by applying federal anti-trust regulations to prevent physicians from self-regulation and working to improve the health care system, 2) by making it difficult for physicians to do office laboratory work for their patients' convenience, 3) by making "safe" drugs expensive because of FDA regulations, 4) by sequentially spawning PRO, PSRO, and now the Health Care Quality Improvement Program (HCQIP) to "assure quality control" (they probably have not paid for themselves), 5) by not using the RBRVS system (accepted by HCFA as a way to relate a physician's fees to the resources required to perform a service) to stimulate physicians to enter primary care practice, 6) by giving tax breaks for insurance costs to big corporations but not to small businesses, and 7) by protecting self-insured businesses from state regulations.

States should be allowed to obtain waivers from ERISA (which incidentally would improve competition) so states could regulate health insurers, try such proposals as a single payer system, or at least restore community rating and equity. This should improve access to technological advances in prevention and health care for all. More commissions and studies and federal laws are not the answer. Health care providers should be able to work together freely to deliver efficient, cost-effective health care. States

should be able to assure preventive services, clinical research, public health support, professional education and care for the poor.

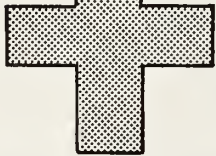
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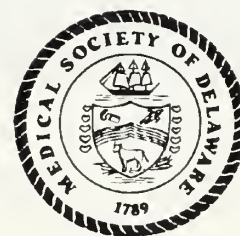
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Proceedings of the House of Delegates, 1995

Part II



Committee on Aging

Reports of Special Committees

Committee on Aging

The Committee on Aging met on a quarterly basis this past year. Meetings were attended by both appointed members of the Medical Society, as well as representatives from outside agencies, including Ms. Eleanor Cain, Director of the State Division of Services for Aging and Adults with Physical Disabilities; Mr. Robert Lawson, Executive Director of the Delaware Healthcare Facilities Association; and Mr. William Winder, Executive Director of the Nemours Health Clinic.

The Division of Services for Aging and Adults with Physical Disabilities is coordinating a speakers' bureau to present health programs for the aging population. Subsequently, the Committee on Aging was requested to assist in this worthwhile endeavor. After communication with the Public and Professional Education and Advocacy Committee, it was recommended that the State Division of Services for Aging and Adults with Physical Disabilities meet directly with the Public and Professional Education and Advocacy Committee to determine ways in which the society can assist in this project.

The Committee on Aging also recommended that the Society support the Annual Geriatric Medicine Symposium held in December 1994.

The Committee on Aging was also a forum for distribution of

information concerning health care and the aged. Updates were provided concerning revisions of the state long term care regulations currently being addressed by a state task force from the Office of Health Facilities Licensing and Certification. Updates and general information were also given concerning the Advance Health Care Directives Task Force, the Governor's Conference on Aging and White House Conference on Aging, the Delaware Health Care Facilities Association, the Nemours Clinics, and the Elder Rights Coalition.

The committee continues to look forward to working with the Division of Services for Aging and Adults with Physical Disabilities, the Delaware Chapter of the AARP, the Delaware Health Care Facilities Association, and the Nemours Health Clinics, especially in joint programs that allow the Medical Society to have an impact and show concern for eldercare health issues.

Wayne C. Zwick MD
Chair

The report was filed.

Charitable Services Committee

The main project of the Charitable Services Committee continues to be the Claymont Health Service at the Claymont Community Center. This program has been running for several years thanks to the volunteer physicians who graciously donate their time to see

Charitable Services Committee

patients at the facility. Our patients number in the thousands at this point in time and patient satisfaction has been high. We are in the process of applying for Medicare approval so that we will be able to bill for Medicare patients and use that as additional funds for the running of the service.

We do continue to solicit volunteer physicians to work on an ongoing basis as we are looking forward to expanding our office hours. In addition, any specialists or subspecialists who would be willing to see a few of these patients in their offices would most certainly be welcomed.

We are always in the market for additional projects. If the membership would bring any such projects to our attention, we would certainly consider them.

Dennis R. Witmer MD
Chair

The report was filed.

Environmental and Public Health Committee

The committee was very active in 1995 having met on January 26, March 23, June 20, September 20 and are planning to meet on November 2, 1995, with focus on the following areas.

Environmental Health Services

Solidified the Medical Society's collaboration with the Division of Public Health (DPH) by liaising with the branch of Environmental Health Evaluation and Toxicology. Dr. Gerald C. Llewellyn, PhD, Branch Chief, met with the committee members and offered to serve as a source of information to physicians when issues of environmental chemical or biological pollution emerged in Delaware.

The branch will distribute one-page fact sheets and other prepared information to targeted physicians through the committee and medical society. Conversely, the committee could support the branch by offering medical expertise when environmental hazard might have impact on the health of Delawareans.

Clinical Preventive Services

The committee decided that we would support the Division of Public Health in the *Healthy Delaware 2000* initiative by promoting prevention in Delaware through the following methods:

- Educating clinicians and the public on the usefulness of evidence-based preventive services.
- Utilizing U.S. Public Health Service Office of Disease Prevention and Health Promotion program (ODPHP) Put Prevention Into Practice (PIPP) program to promote such services. The program includes age charts for recommended periodic health examinations, a handbook providing justifications for the recommendations, templates for individualized patient record flow sheets, posters, alert stickers, and other promotional tools.
- Pilot the program with 30 Delaware physicians in family practice, internal medicine and pediatrics to determine usefulness of material and best method of approach.
- Endorsement of PPIP and the pilot program by the Medical Society's Board of Trustees.

This proposal was presented to the Board of Trustees on July 13, 1995, and was approved. The 30 clinicians have been selected and are in the process of being contacted through mail and personal contact by committee members. It is anticipated that at the completion of the pilot program, a

**Environmental and
Public Health
Committee**

**Environmental
Health Services**

**Clinical
Preventive Services**

full scale effort of marketing the program with physicians and the public will be initiated. This will probably take place in 1996.

Advocacy positions have been adopted in the following areas:

- Loss of funding for the Office of Disease Prevention and Health Promotion (ODPHP), which developed the Healthy People 2000 national prevention strategy and all associated educational campaigns, including PPIP.
- National budget cutbacks that would impact on environmental protection legislation protecting air, soil and waters and ultimately the health of the public.

Both issues were submitted to the Society's Board of Trustees at the September 14 meeting. The Board adopted the committee's recommendation of contacting Delaware's Congressional delegation and administrations to express concern over loss of funding for ODPHP and noted the committee's concern regarding the environmental cutbacks.

Athena T. Jolly MD
Chair

The report was filed with commendation to the committee for its initiative and the recommendation that an article be published in the *Delaware Medical Journal* informing members of the Put Prevention into Practice Program.

Maternal and Child Care Committee

A major focus of the Maternal and Child Care Committee during 1995 has continued to be HIV screening of obstetrical patients. The committee membership has continued to feel that it is appropriate to screen all obstetri-

cal patients on a mandatory basis. Many of the members of the committee feel that HIV screening is analogous to screening for other sexually transmitted diseases. Early in the year, the committee sent a recommendation to the Board of Trustees of the Medical Society, again recommending mandatory testing. This was negatively acted upon by the Board of Trustees, who felt that the resolution that was adopted at last year's annual meeting was appropriate and in line with the guidelines provided by the federal government.

At the most recent meeting of the Maternal and Child Care Committee, a recommendation was made that the Board of Trustees request that the legislature authorize the insurance commissioner to require that all companies that provide insurance for obstetrical care pay for HIV testing in their obstetrical patients.

During the past year a pilot Child Death Review Panel was convened as a joint effort of the Attorney General's office, the Department of Children, Youth and their Families, and the Department of Health and Social Services. The scope of this project was to review the deaths of all children under the age of 18 years in New Castle County during the past year. This panel has been quite successful in making recommendations to appropriate agencies concerning management of problems identified by the panel.

In its last session, the legislature passed the appropriate hold harmless legislation to establish Child Death Review Panels in all three counties and at the state level. Unfortunately, there is neither time nor money to cover all perinatal deaths, including stillbirths. As a consequence, the establishment of Child Death Review Panels may be an opportunity for the Medical Society and

Maternal and Child Care Committee



Medical Society members and guests gather at the Hotel DuPont for the Annual Dinner Dance.

the Child Death Review Panels to work cooperatively in soliciting funds from the National Fetal and Infant Mortality Review Project for funds to provide the complete scope of perinatal mortality surveillance.

On the infant mortality front, the *News Journal* has supported a series of articles during the past year. These articles, "Cradle of Sorrow," were followed by a symposium entitled "Cradle of Hope," which addressed the issue of infant mortality in the state of Delaware. One of the major recommendations resulting from the symposium was the establishment of a Perinatal Board. The Maternal and Child Care Committee supports the establishment of a Perinatal Board and solicited the support of the Board of Trustees of the Medical Society to seek the establishment of Perinatal Board by either the legislature or Governor Carper.

Prevention of child abuse is an issue that has frequently come before this committee. As a consequence, Kathryn Way, Director of the State Division of Family Services, was invited to speak with the committee. She discussed how her division is being revamped. The members of the committee offered to help this endeavor in any way possible.

Another subject that has frequently come before the committee is that of pregnant substance abusing women. Dr. Maria Perez and Ms. Kay Malone of Brandywine Counseling, Inc., met with the committee to discuss this issue. Dr. Perez and Ms. Malone noted that there is no in-patient facility available for methadone patients and the facilities for other substance abusing women are inadequate. As a result of these discussions, the committee urged the Board of Trustees to encourage the state of Delaware to fund a facility to provide counseling, medical, and obstetri-

cal services for pregnant women with drug addiction (including opiates) and their children.

The committee had a number of concerns pertaining to House Bill 179 relating to notice of abortions performed on minors. The committee felt that this bill was ill-advised and that the legislature should reconsider it. However, since the Bill was to become effective on October 1, 1995, and it is unlikely that it will be rescinded, and since most physicians are not clear as to the stipulations of the bill, the committee requested that the State give all physicians appropriate explanatory materials in English and Spanish outlining the provisions of the bill and the appeal process available to minors.

Garrett H. C. Colmorgen MD
Chair

The report was filed. The following recommendations of the Reference Committee were adopted by the House of Delegates: 1) That the Maternal and Child Health Committee be asked to report back to the Board of Trustees on the issue of mandatory HIV testing with a recommendation based on scientific evidence; and 2) that the Public Laws Committee be asked to draft legislation to insure that insurance companies pay for prenatal HIV testing.

Medicine and Religion Committee

The focus of activity for the Medicine and Religion Committee has been the Prayer Breakfast at the annual meeting of the Medical Society of Delaware held in November. We had discussed and entertained the notion of sponsoring another physician/clergy breakfast, but there seemed to be little interest among committee

Medicine and Religion Committee

members. If the general membership feels a physician/clergy breakfast is an invaluable and worthwhile project, we will certainly do our best to have such a program in the future.

Dennis R. Witmer MD
Chair

The report was filed.

Medico-Legal Affairs Committee/Joint Committee of Physicians and Attorneys

During the past year, we received a request from the chairperson of the Medical/Dental Legal Relations Committee of the Delaware State Bar Association to review physician charges associated with legal process.

Historically, a Joint Committee of Physicians and Attorneys (including one judge) addressed this matter at the request of the Superior Court and made recommendations to the courts of the amount of fees that it was felt would be reasonable to be taxed to the losing litigant as part of court costs. The past 12 years have, of course, produced significant economic changes, and the 1983 recommendations needed to be re-addressed.

This committee had a number of meetings during the past year with representatives of the Medical/Dental Legal Relations Committee which resulted in a consensus of the range of fees that would be appropriate. These recommendations were passed to the respective Boards which approve of them and also on to the Superior Court.

It should be noted that neither this committee nor the Medical Society has recommended that these are the fees physicians should charge but merely the ones that the court can allow as expert fees in litigation process.

At the time this report was dictated, preliminary plans are

underway for a Joint Medico-Legal dinner and seminar. Dates and topic have not yet been finalized.

The Chair of the Medical/Dental Legal Relations Committee is also organizing a legal review of the Interprofessional Code, which has remained dormant for some time.

John T. Hogan MD, FACS
Chair

The report was filed.

Mental Health, Alcoholism, and Drug Abuse Committee

The committee remains largely inactive but keeps in touch with affiliated people and committees addressing these issues. These include the Psychiatric Society of Delaware and the Delaware Coalition of Mental Health Professionals.

Together, and under my direction, we have crafted HB 340, an important piece of legislation which would assure parity in coverage for mental health, substance abuse, and emotional disorders with that for physical disorders. This is in committee now in the House and should come to vote in the second half of the legislative session.

We have polled many physicians and there is widespread support for this legislation. It is important that the MSD continues to support the legislation.

Neil S. Kaye MD
Chair

The report was filed.

Pharmacy Committee

At the time of submission of this report, the Pharmacy Committee had met once during this year. On Tuesday, July 25, 1995, the committee met at the Delaware Academy of Medicine building.

The following issues were ad-

Medico-Legal Affairs Committee/Joint Committee of Physicians and Attorneys

Mental Health, Alcoholism, and Drug Abuse Committee

Pharmacy Committee

dressed by the committee during 1995:

A. Faxing Prescriptions

This year the Delaware State Board of Pharmacy formulated specific policies concerning the faxing of prescriptions. Prior to issuing their final recommendations, the Board of Pharmacy requested input from the Medical Society. Formal input was provided by the Pharmacy Committee to the State Board of Pharmacy concerning the adverse impact some of the policy requirements would have on physicians. Subsequently, a revised policy was formulated by the Board of Pharmacy and submitted for further comment. The Pharmacy Committee discussed the final regulations and concluded that they were appropriate for the convenient and safe transmission of prescriptions via fax for the benefit of Delaware patients.

B. Time Limit on Prescriptions

The Delaware State Board of Pharmacy requested input from the Medical Society concerning the time limit beyond which prescriptions should no longer be considered valid. The Pharmacy Committee provided input to the Board of Pharmacy which will be considered when the Board reviews this policy.

C. Drug Utilization Review Board

Members from the Pharmacy Committee continue to be active participants in the State Drug Utilization Review Board. Procedures for prospectively and retrospectively reviewing pharmaceutical use within the state of Delaware are being developed along with educational projects to improve the application of drugs to various disease states.

D. Liaisons with State Agencies Concerning Pharmaceutical Concerns

The Pharmacy Committee con-

tinues to be in close contact with the State Board of Pharmacy, the Delaware Pharmaceutical Society, and the Controlled Substances Act Advisory Committee. Members from these groups continue to be in attendance at the meeting of the Pharmacy Committee.

Michael J. Pasquale MD
Chair

The report was filed with the request that the Board of Trustees recruit more support for this valuable committee.

Physicians' Health Committee

The Physicians' Health Committee has continued its work with a number of new referrals, as well as continued monitoring of existing cases. The scope of problems continues to be varied, with issues including depression, substance abuse, sexual misconduct, litigation stress and other stressors. A new treatment contract has been put into place, which is updated and reflects current national guidelines and those of the Federation of State Medical Boards.

The committee's relationship with the Board of Medical Practice has continued in a very positive and collaborative effort. The committee made an educational presentation to the Board, which was well-received.

In an effort to educate the medical community about the committee's work and to foster hospital-based efforts to deal with physicians with various difficulties, the committee requested copies of existing policies with regard to impaired physicians from all Delaware hospitals and held a dinner meeting, with a representative from each hospital invited, to discuss this issue and share ideas.

Physicians' Health Committee

It is the committee's privilege to continue to serve and advocate for Delaware's physicians.

Carol A. Tavani MD
Chair

The report was filed with commendation to Dr. Carol A. Tavani and her committee members for the outstanding work that this committee has done on behalf of physicians in our community.

Prison Health Committee

In the course of the past year, the Prison Health Committee has had two meetings, which have been helpful to us but not to the population of the prisons. A committee meeting was held on March 7, 1995, which was broad ranging, discussing information about a few patient problems, which have been resolved, and our relation to the Delaware Center for Justice Board. A meeting on August 16, 1995, with Mr. William Killen, Public Defender's Office; Mr. Philip Corrozi, MSD Legislative Specialist; Mr. Mark Meister; Ms. Beverly Dieffenbach and myself went over a number of problems, which seem to be quite general and for which we do not seem to be able to generate much interest on the part of government. Our major effort has been to have an ombudsman designated for the prison population, but we received no answer to letters to the Governor. Mr. Philip Corrozi expressed the feeling that this would take a great deal of persuasion to be successful.

Some of the problems we have discovered are not of immediate concern in terms of difficulties for inmates but, overall, I think are very important. Perhaps a listing of them would suffice to inform you.

- 1) There seems to be no care for psychiatric problems.
- 2) Most prisons throughout the

country have a detoxification center as part of the system, but Delaware does not.

- 3) Not an insignificant step is that Mr. William Killen of the Public Defenders office no longer has a car provided despite the fact he has a great deal of traveling to do.
- 4) There does not seem to be close follow-up of patients who have been on methadone and have been taken off.

It was strongly suggested that a joint effort by the Medical Society of Delaware, the Delaware Bar Association, the Delaware Center for Justice and the Public Defenders Office should be called together to try to propose a good ombudsman program. It is clear the ombudsman must be totally independent and report only to the Governor. I think it should be noted the feeling seemed very strong on the part of people at the meeting that, other than doctors, the appointments to the Parole Board have been inappropriate.

Charles L. Minor MD
Chair

The report was filed with the recommendation to the Board of Trustees that the Society collaborate with the Delaware Bar Association, the Delaware Center for Justice and the Public Defender's Office to establish a working ombudsman program.

School Health Committee

The School Health Committee met twice in the past year, once on November 22, 1994, and once on March 8, 1995. Both meetings were well attended and the site of vigorous and healthy debate.

The major topic of discussion was perceived problems between school nurses and school-based health clinics. One outcome of these meetings is the agreement on the part of Dr. Charles

Prison Health Committee

School Health Committee

Konigsberg, Director of the Division of Public Health, to charter and co-chair a group which will address better utilization of resources for school health. The Medical Society has been asked to participate in this group.

Diana Dickson-Witmer MD
Chair

The report was filed with the Reference Committee's recommendation regarding stressing health record confidentiality in school-based health clinics and better communication between the school-based health clinic and the primary care physician.

Report of Ad Hoc Advisory Committee to the Board of Medical Practice

Members of the committee made themselves available to the Board of Medical Practice as needed during the past year.

The Advisory Committee to the Board of Medical Practice was formed over a year ago to assist the Board of Medical Practice in adjudication of allegations concerning physicians about whom a preliminary investigation by the Board has determined that reason exists for the Board to take definitive actions. The advisors are not paid for their efforts.

Martin Gibbs MD
Chairman

Dr. Diana Dickson-Witmer, President of the Board of Medical Practice, stated that the Board very much appreciates this advisory committee and its expertise in evaluating cases before the Board but noted that the Board of Medical Practice also requires the willingness of experts reviewing cases to testify at hearings pertaining to these evaluations. A motion was

adopted to file the report and to move the comments to the Board of Trustees with the suggestions that the Board of Trustees consider providing legal consultation to any expert asked to testify so that those individuals can be assured of the statutory immunity that comes with testimony before the Board of Medical Practice or one of its panels.

Report of Council of Specialty Societies

Representatives of the specialty societies were invited to submit reports for inclusion in the House of Delegates handbook.

Delaware Thoracic Society

The Delaware Thoracic Society, a chapter of the American Thoracic Society and the medical arm of the American Lung Association of Delaware, has recently been formed. The focus of this organization will be the scientific, clinical, educational, and public health issues that relate to respiratory medicine. The Delaware Thoracic Society will serve as a resource on medical matters for the American Lung Association of Delaware.

During the preceding year, the Delaware Thoracic Society supported the Respiratory Care Act, which was signed into law by the Governor.

The annual meeting of the Delaware Thoracic Society is held in April of each year, in conjunction with the *Perspectives in Pulmonary Medicine* symposium.

Joseph F. Kestner Jr., MD
President

The report was filed.

Delaware Urological Society

The Delaware Urological Society recently met on September 22, 1995, and there were no major

**Report of Ad Hoc
Advisory Committee
to the Board of
Medical Practice**

**Report of the
Specialty Societies**

issues in particular concerning the Delaware urologists in attendance. Of course, the Delaware urologists, like other physicians in the country, are concerned about the delivery of health care. Whether the present quality of health care will still be viable, with the change towards managed care, remains to be seen.

The Delaware Urological Society's Annual Dinner meeting began with a Grand Round, at which complex urological cases were presented and discussed with the visiting professor, followed by a business meeting and annual dinner, after which Barry Stein MD, Professor and Chairman of the Department of Urology at the Rhode Island Medical School in Providence, Rhode Island, presented a lecture about Surgical Alternatives to TUR, "Where Are We Now?"

Alex M. Raney MD, FACS
President

The report was filed.

American College of Obstetrics and Gynecology, Delaware Section

In a spirit of unity, the Delaware Section of ACOG established a new category of adjunct memberships for obstetrician gynecologists who are ineligible for college fellowship. This broadened our working base. The local section unanimously voted to support the endeavors of the State Ob-Gyn Society to encourage the passage of legislation to make HIV testing of pregnant women mandatory. The district (which includes Pennsylvania, Delaware and New Jersey) was also polled regarding their sentiments. The overwhelming majority strongly support mandatory HIV testing to identify mothers at risk and decrease the maternal fetal transmission.

While we were mobilizing to contact the representatives in

Dover regarding insurance companies forcing postpartum patients out of the hospital before it was felt to be medically proper, the House of Representatives formed a task force to study the matter. We are anxiously awaiting the report of that task force. While we are opposed to the concept of government management of medical care, we are looking for a solution to the problem of "drive-in deliveries." We also continue to deal with the problem of being identified as primary care physicians.

Anna M. D'Amico MD
Chair

The report was filed.

Delaware Chapter of American College of Gastroenterology

The gastroenterologists of Delaware have remained very active with many ongoing activities. This includes continuing teaching of house staff at the Medical Center of Delaware and St. Francis Hospital. Gastroenterologists have not only taught one-on-one to residents performing gastroenterology rotations, but have served as the teaching attending for Internal Medicine services. The Section of Gastroenterology has also been involved in arranging speakers for Thursday morning Christiana Grand Rounds and Tuesday morning Academy of Medicine conferences.

The majority of gastroenterologists in this community have also come together to develop, build and begin operation of the Endoscopy Center of Delaware. This is an out-patient, ambulatory, state-of-the-art, free-standing endoscopy center. It has been designed to be extremely patient-oriented with a very pleasant out-patient environment, while at the same time be less expensive than endoscopy at the current hospital GI labs. This will be a Medicare

Delaware Thoracic Society

Delaware Urological Society

Delaware Chapter of American College of Gastroenterology

American College of Obstetrics and Gynecology, Delaware Section

certified, completely staffed center. The gastroenterologists in the community are extremely excited about this project, since such endoscopy centers are the trend nationally.

Several gastroenterologists have also been involved with the Research Institute at the Medical Center involving eradication of *Helicobacter Pylori* in duodenal ulcer patients and healing of NSAID-induced upper GI tract lesions.

Joseph F. Hacker III, MD
Governor

The report was filed.

Delaware Academy of Family Physicians

Once again the Delaware Chapter of the American Academy of Family Physicians has been active in our community and in key positions within our state. I am happy to bring you up to date on these.

Doctor Rhoslyn J. Bishoff was awarded the Distinguished Service Award for his many years of dedicated service to the Academy and the State of Delaware. Doctor Lawrence M. Markman was presented with the Outstanding Service Award in recognition and appreciation of his leadership in the Delaware Chapter and his devotion to represent ably the interests of the Delaware Family Physicians at the American Academy of Family Physicians.

Doctor Lemuel Herrera has been nominated (posthumously) for the Family Doctor of the Year Award, 1996. Doctor Herrera was always active and willing in educating family physicians and supporting the concepts of our specialty.

Doctor William Funk has been active along with Sandra Hitchens, RN, in completing a practical pediatric flow sheet to facilitate recording and transfer of health

information. Doctor Funk has also been appointed Chairman of the Education Committee for the state of Delaware. In this capacity he will review and approve all Continuing Medical Education programs submitted on 102 Forms prior to their submission to the AAFP.

Our winter and fall courses have been well-attended by physicians and nurses alike. For the third consecutive year, the September Quarterly meeting was held at the Banking House Inn in Milford, Delaware. This represents a continuing trend to make Academy activities accessible to members in Kent and Sussex Counties. Plans are also in place to have the Annual Scientific Meeting in Dewey Beach, Delaware, this coming May.

The Delaware Academy of Family Physicians Research and Education Foundation, under the direction of Doctor M. Diana Metzger, has been active in promoting grants and fellowships to students, in supporting research in various aspects of preventive care, and in supporting the annual Geriatric Medicine Symposium.

Our Legislative Committee has been active through Doctor Rhoslyn Bishoff in keeping us up to date on the activities of our General Assembly. Of particular concern (to name a few) are HB 12, which establishes a public employee occupational safety and health act with procedures for implementation, and civil and criminal penalties; and HB 64, which creates a presumption in favor of the claimant on those issues in a hearing before the Industrial Accident Board. In the future, Doctor Stephanie Malleus has agreed to represent the Academy in this capacity.

One of the major objectives of our body is the union in purpose and by the active "networking" of our membership to fight for our

Delaware Academy of Family Physicians

right to serve our patients within the capabilities of each individual physician's training. The frustrating battle for procedure privileges continues and yet we are even more determined to prove that family physicians, with special interest training and expertise in certain areas of medicine and surgery, can be capable of providing services and procedures for their patients.

The DAFP supported the AAFP Resident Repayment Program by providing a five-year commitment of \$1,000 per year. This program helps residents committed to practice in rural and inner city areas and as family practice teachers by paying up to \$2,500 per year of the interest on their loans while they are in a family practice residency program and their first year in practice.

The Academy finished a three-year commitment of \$1,000 per year to Nursing Mothers, Inc. to supply breast feeding support packets to new mothers.

As you see, we have been very busy this year, and yet much more work awaits us.

Julio E. Navarro MD
President

The report was filed.

Delaware Academy of Ophthalmology

The Delaware Academy of Ophthalmology continues to remain active in governmental activities. The therapeutic optometrist bill was passed in 1994, and since that time a proposal has been made to amend the Medical Practice Act to define surgery and in particular laser surgery. Our society continues to support this measure as proposed by the Medical Society. With FDA approval of the Eximer laser, this will set the stage for optometrists to consider further legislation, as they are in many states, to include laser surgery as part of their therapeutic

armamentarium. The Delaware Academy of Ophthalmology also continues to support the Medical Society of Delaware's proposed amendment that a regulatory council be created for therapeutic optometrists. In the past, the governor has viewed this favorably. We would encourage the Medical Society to continue to pursue this course of action. We continue to retain lobbyists on a surveillance basis for the Delaware Academy of Ophthalmology but hope to continue to work with the Medical Society's lobbyist to promote these issues.

Our Academy continues to hold quarterly educational dinners and is continuing to work to provide both a stimulating environment for educating our local ophthalmologists on new issues in ophthalmology. Our educational chair has also worked to gain CME credits for these meetings, which has been met favorably by our members. In January, which is National Eye Care Month, we are co-sponsoring a vision screening with the Lions clubs and have asked to participate in the Optic Foundation's national public relations billboard campaign which is usually done in January. We are awaiting sponsorship from some of the local billboard companies for this. We hope to make more of our citizens aware of the importance of good eye care.

Our executive council is attempting to institute a newsletter for our members, as well as quarterly executive committee meetings. Our major goals for 1996 are to consider increasing our membership, enhancing relationships in cooperation with optometry and to continue to work with the Medical Society on any governmental issues pertinent to medicine, as well as ophthalmology.

Dorothy M. Moore MD
President

The report was filed.

Delaware Academy of Ophthalmology



The Dinner Dance gave physicians from across the state an opportunity to socialize with their colleagues.

Delaware Chapter of American College of Physicians

Delaware Chapter of American College of Physicians

The Delaware Chapter of the American College of Physicians continues to be an active organization whose specific goals are to foster continuing education and collegiality between attending and associate members. To accomplish this, we have a yearly scientific meeting held in February which has been extremely successful. It has attracted 50 or more physicians for several years, accounting for over 20 percent of the membership of our chapter.

In addition, the American College of Physicians has begun a program of sponsoring journal clubs for the internal medicine residents at the Medical Center of Delaware which focus on ethics and the doctor-patient relationship as well as other non-scientific issues affecting physicians in practice. The College has also sponsored, on occasion, a special Grand Rounds presentation at Christiana Hospital, particularly in the realm of public policy and managed care. The College has also been active in public policy, providing information to our senators and congressmen and lobbying them on a yearly basis as to the position statements of the National College of Physicians.

Finally, the chapter has been involved in promoting collegiality by sponsoring a yearly picnic and softball game for attending members and house staff.

James H. Newman MD
Chair

The report was filed.

Delaware Society of Anesthesiologists

The Delaware Society of Anesthesiologists has focused much of its effort this past year looking at economic factors that are important for health care delivery in a

managed care environment. In particular, we have concentrated on areas which are relevant to anesthesiologists. Our Annual Meeting, which was held in March 1995, featured a nationally recognized speaker, Laura Tarlow, who spoke on Economic Issues and Capitation Reimbursement in a Managed Care Setting.

Members of the Society have also been active in their own hospitals in a number of other areas during the past year. Quality of care issues have received continuing attention, and economic considerations in the delivery of efficient services are under scrutiny. For example, cost-effectiveness in the choice of the drugs we use has been a key consideration for all of us.

Several new anesthesiologists have moved into the state this past year and have become active members of the Delaware Society of Anesthesiologists.

In summary, the activities and interests of our Society represent those which are of importance to all physicians in our state.

Richard N. Hindin MD
President

The report was filed.

Delaware College, Occupational and Environmental Medicine

DCOEM has four quarterly meetings per year. This year the educational programs at these meetings featured Dr. James Nethercott from the University of Maryland who spoke on Occupational Dermatology and placement of people with dermatoses under the ADA.

Dr. Jeffrey Kahn, an occupational psychiatrist, spoke about occupational stress and when this is truly a significant factor. A stimulating discussion followed this presentation.

At our joint meeting with the

Delaware Society of Anesthesiologists

Delaware College, Occupational and Environmental Medicine

occupational health nurses, Dr. Cal Furchman, Chief of Pulmonary Medicine at Harbour General Hospital in Baltimore, spoke on "Keeping People with Respiratory Disease at Work."

Also during the year, Dr. Goldstein presented Grand Rounds at Christiana Medical Center on Clinical Practice Guidelines on the Treatment of Low Back Pain in Adults. Dr. Goldstein was a peer and pilot reviewer on this subject for the Agency for Health Care Policy and Research, a division of the Department of Health and Social Services.

Also, Dr. Raymond Strocko of DuPont and a past president of DCOEM spoke at the American Occupational Health conference in Las Vegas in May of this year. At the same conference, Dr. Goldstein moderated a full-day educational symposium on *Worker Fitness-Clinical Versus Mechanical Evaluation*.

Four new members were added to our membership during the year. Membership is available to MDs or DOs who have an interest in or a desire to increase their expertise in the various aspects of Occupational Medicine.

As an organization that frequently deals with disability evaluations, we feel that sometimes the decisions of the Delaware Disability Determinations Office require more in-depth evaluation, and we feel that there should be some kind of audit of exactly how they do their disability evaluation process.

Garry A. Goldstein MD
President

The report was filed.

Asthma, Allergy and Immunology Society of Delaware

Over the past year our activities have consisted of a public lecture on asthma to teens in the community as well as continuing

education lectures to the various teaching programs in internal medicine, family practice, and pediatrics in our community.

The Society has represented the members of our society dealing with various insurance companies concerning various administrative matters in the use of CPT coding. I anticipate that this will be the continuing format of our activities in the upcoming year.

William J. Geimeier MD
President

The report was filed.

Delaware Chapter of the American College of Surgeons

The Council of the Delaware Chapter of the American College of Surgeons recently endorsed the enclosed statement of Dr. Paul Ebert, ACS Director, regarding the recent negotiations between the American Medical Association and the House Republicans. He points out that their "commitment" not to reduce Medicare payments to doctors treating Medicare patients does not hold true for surgeons. Their promise to not roll back fees is true only in the aggregate, but for surgeons there would be a payment decrease of approximately 10 percent for all services performed after January 1, 1996.

The American College of Surgeons has not endorsed the House leadership package. Even the "sweeteners" negotiated by the American Medical Association cannot offset the impact that the payment reductions will have on surgeons. The revisions to the MVPS system will benefit all physicians, but only surgeons — who were in compliance with Congressional intent by keeping the spending for their services well below the rates set by government — would be heavily penalized to finance the revisions. It is not fair for surgeons to bear

**Asthma, Allergy
and Immunology
Society of Delaware**

**Delaware Chapter
of the American
College of Surgeons**

the sole financial responsibility for provisions that would benefit the entire medical community.

The American College of Surgeons continues to support separate MVPS and fee schedule conversion factors for surgical service. If a single fee schedule conversion factor is established, the American College of Surgeons insists that such a policy change must include a transition period in order to minimize disruption to surgeons and their patients.

We are very concerned about these issues and will continue to make our feelings known.

Delaware Society of Orthopaedics Surgeons

Rafael A. Zaragoza MD
President

The report was filed.

Delaware Society of Orthopaedic Surgeons

The Delaware Society of Orthopaedic Surgeons has been concerned with changes in the health care delivery system and especially in regard to managed care and capitation. There have been negotiations with the insurance companies by individuals and groups of orthopaedic surgeons whose main focus has been to preserve the patient's freedom of choice. It is felt at times that referrals to specialists have been delayed or denied by the insurance companies. This has had an adverse effect on the quality of patient care and in the long run is not cost effective.

The annual meeting of the Delaware Society of Orthopaedic Surgeons is planned for November 10, 1995. At the meeting, in addition to a very interesting scientific presentation by members and guest speakers, the above matters will also be discussed.

Mohammad Kamali MD
President

The report was filed.

Delaware State Osteopathic Medical Society

Delaware State Osteopathic Medical Society

Over the course of the past year, the Delaware State Osteopathic Medical Society has continued to hold meetings at both an executive committee and membership level. Quarterly membership meetings have been held regularly with educational topics presented. The upcoming educational fall seminar is scheduled for December 2, 1995, and will be chaired by Dr. Anthony Alfieri.

Throughout the course of the year, managed care issues have been addressed in addition to Medicare and Medicaid issues. Current active discussion in regard to specific osteopathic services is being held among members, as well as managed care organizations.

Newly elected officers for the 1996-97 term include:

President	Barry Bakst DO
Vice President	John DeCarli DO
Secretary	James Fierro DO
Treasurer	Elizabeth Jackovic DO
Member at Large	Ira Epstein DO

Andrew J. Gelman DO
President

The report was filed.

Psychiatric Society of Delaware

This past year, the Psychiatric Society of Delaware, under the presidential leadership of Charles O. Webber MD, has continued to advocate in behalf of our patients and private sectors. Continued growth in the educational and training programs and grand rounds at the Delaware State Hospital have reaffirmed the importance of public psychiatry and the developing provision of services to a wide variety of patients and families, side by side with for-profit and not-for-profit hospitals, agencies and practices in the fields of psychiatry and

Psychiatric Society of Delaware

mental health. Continued hard work and advocacy by Dr. Ashley Angert through the Private Practice and Managed Care Committee for public/private intercooperation and integration for children and families has been seminal in planting the concept for public/private cooperation in the minds of legislators, as well as those developing mental health components of new Medicaid privatized contracts. Our society has, per our commitment of the last year, strengthened the position of our Executive Secretary, Mary LaJudice, which has helped us to disseminate needed educational and administrative information quickly and effectively. We have expanded the role of fax machines for rapid communication of Society business and decision-making to be more responsive to the needs of the membership as a whole. Dr. Mark Borer and Mary LaJudice have completed the compilation of a membership directory listing not only the names and addresses of psychiatrists within each county in Delaware, but we have also, through the use of surveys, been able to list such information as specialty boarding, areas of clinical interest and expertise, and areas of interface as point persons for various managed care and other mental health organizations. This has allowed our membership more ready access to the specific expertise of colleagues needed for patient referral and networking.

The Psychiatric Society has continued to support advocacy for our patients through conjoined activities with other mental health advocacy organizations, such as supporting May as Mental Health Month and Mental Illness Awareness Week with the Alliance for the Mentally Ill in Delaware (AMID) and the Mental Health Association. We presented Representative Jane Maroney with the Area III Warren Williams Award for her service and

support for legislation regarding the needs of children and underprivileged in the state of Delaware. We have provided detailed input to the national organization regarding the importance of recruitment and retention of psychiatrists to serve the needs of our patients in the future. Although some managed care surveys indicate a potential oversupply of psychiatrists, according to the HMO model of psychiatric service delivery, our organization believes that this does not adequately account for the numerous psychiatrists which will be needed in the future for meeting the needs of those currently served with psychotherapy and psychopharmacologic interventions through private practice, those serving the severely mentally ill, and those involved in education and training of residents, as well as consulting to our colleagues in other specialties. Our organization as a whole continues to support the AMA platform for choice of patients in choosing their own physician and to reassert the importance of allowing various forms of service delivery to compete both in Medicare reform and in future health service delivery in the private sector. We support not only our members working with HMOs in development of capitated contracts, but also our members working in traditional fee-for-service modes of delivery and those involved with point of service plans. We continue to support and advocate the development of physician organizations and strong psychiatric leadership in PHOs. We continue to support development of appropriate strategies to maintain quality work under reduced reimbursement systems including, but not limited to, those moving toward capitated fee arrangements.

Our organization continues to participate in the national



Over 100 physicians and their guests gathered at the Hotel duPont on Saturday, November 18, 1995, to see the inauguration of Carol A. Tavani MD.

American College of Cardiology

organization's development of treatment guidelines, including treatment guidelines for depression and bipolar disorder, as well as for treatment of addiction disorders. Our Ethics Committee, under the joint leadership of Doctors Mary Lou Hale and Neil Kaye, continues to assist in the review and appropriate support of our fellow organizations in investigating any ethical complaints brought before us. The Psychiatric Society continues to advocate for a parity bill, introduced along with the Medical Society of Delaware and the Delaware Coalition of Mental Health Providers, in order to stop the inappropriate under-reimbursement of necessary treatment for those with mental illness. The Psychiatric Society continues to take part in advising Blue Cross and Blue Shield and the state of Delaware on the appropriate role of psychiatrists in capitated systems of care. Dr. Jorge Pereira-Ogan has been reappointed to the Governor's Advisory Council on Alcohol, Drugs and Mental Health and has served as Chair of that Council. Dr. Mark Borer has been elected a Fellow of the American Psychiatric Association, an honor which was possible through the support and hard work of many of those in the Council of the Psychiatric Society of Delaware.

Dr. Jose Capiro, our incoming President, has promised to expand the roles of the committees in the function of the Psychiatric Society and has rededicated the Psychiatric Society to the continued advocacy for the needs of the severely mentally ill and underprivileged in Delaware. We continue to thank the efforts of all of the Psychiatric Society of Delaware membership, and particularly those extra efforts by those who give of their time to the Council.

Mark S. Borer MD
President

The report was filed.

American College of Cardiology

Although our members have concerns about all of the usual specialist issues (such as patient access to specialists, etc.), one additional issue has been of particular concern. That is, several insurance companies have insisted that their insured patients go to Philadelphia or elsewhere to have invasive procedures, such as catheterization, angioplasty or bypass surgery. Although at times this is not terribly difficult for the patients, often this comes in the middle of a hospitalization for an unstable cardiac syndrome, such as unstable angina or acute myocardial infarction. While it is probably "safe" for these patients to travel to these places, it is extremely difficult for the patients both emotionally and logistically. Most of them want no part of being uprooted and going to another hospital 40 miles up the road, especially insofar as it removes them from their family and support system, etc. Such transfers are particularly aggravating when it is known that the outcomes at one or another of the institutions the patients are being sent to are not as good as ours in the particular area.

Andrew J. Doorey MD
Governor

The report was filed.

*Reports of Liaisons
and Representatives*

Delaware Foundation for Medical Services, Ltd.

The Delaware Foundation for Medical Services, Ltd. (the Voluntary Initiative Program of the Medical Society of Delaware) has had a most successful year. Since the inception of the program we have found a medical home for close to 3,925 patients who are beneficiaries in the Medicaid

program. Currently we are averaging 120 successful placements a month with approximately one-half of these being with family practitioners and a little better than one-quarter of these being with pediatricians. All reports indicate there is a high rate of compliance with appointments made for Medicaid patients through this program and a high degree of satisfaction expressed by the recipients of these services. Likewise, the fact that this disadvantaged population is spread across a large number of generous and caring physicians has lightened the load for all of us and is a reflection of the benevolence of members of the Medical Society of Delaware.

I am pleased to report that our fund drive was successful, having raised in excess of \$100,000, sufficient to capture the \$100,000 matching grant from the Longwood Foundation. Because of this success, the total raised is in the amount of \$204,000. With this infusion of monies, there is sufficient funding to insure the continuation of the program for the next three to four years, during which time we can expect to see the implementation of a Medical Society program to address the provision of care to the indigent. We expect that the structure created by the VIP program would be retained to implement the Medical Care for the Indigent Program and will enable us to make use of the considerable experience we have gained in the development and day-to-day operation of the VIP program.

Joseph A. Lieberman III MD, MPH
Chairman

The report was filed.

Delaware Institute of Medical Education and Research (DIMER)

The membership of the Board of Trustees of DIMER has been

altered this year with the appointment of Ms. Shirley Tarrant, G. Dean MacEwen MD; Rosalina deJesus MD; and William Newcomb MD, Ms. Tarrant and Dr. MacEwen were appointed by the Board of Directors of the Medical Center of Delaware to replace Leslie Whitney MD, and Robert L. Richards. Dr. deJesus and Dr. Newcomb were appointed by Governor Carper with the advice and consent of the State Senate to replace Michael Axe MD, and Harry Freedman MD

The present membership is: University of Delaware, Sherman L. Townsend, Chair; Dean Betty J. Paulanka, Ed.D.; and Pierre D. Hayward; Medical Center of Delaware, Charles M. Smith MD, MPH; G. Dean MacEwen MD; and William A. Newcomb MD; Governor, Shirley M. Tarrant, Rosalina deJesus MD; and John A. J. Forest MD; and Executive Director, Leslie W. Whitney MD.

The Annual Budget FY '96 is:
Jefferson Medical College

	\$1,000,000
University of Delaware	
	\$50,000
Medical Center of Delaware	
	\$200,000
Loans	
	\$400,000
Delaware Academy of Medicine	
	\$1,000

The number of DIMER students enrolled at Jefferson is:

Freshmen	21
Sophomores	19
Juniors	15
Seniors	25

The Scholarship Program has been changed to a loan program. The program is no longer based on demonstrated need but rather by the agreement on the part of the recipient to return to Delaware to practice Internal Medicine, Pediatrics, Family & Community Medicine, or Ob/Gyn. Each yearly tuition loan will be forgiven without interest for each year served in Delaware providing primary care.

Reports of the Liaisons and Representatives

Delaware Foundation for Medical Services, Ltd.

Delaware Institute of Medical Education and Research (DIMER)

To date, 17 loans have been granted to DIMER students who have signed a loan agreement promising to return to Delaware to practice. This includes five first-years, five second-years, five third-years, one fourth-year, and one student who has graduated and is now a resident at the Medical Center of Delaware. Loans are monitored by the Committee on Higher Education, which is responsible for collection of the loan in case of default.

DIMER is presently undergoing extensive review by the Joint Sunset Committee of the General Assembly as required by Delaware law. After an extensive preliminary review which resulted in several recommendations for change or improvement, many of which have already been instituted, the review was continued and referred to the Primary Care Committee of the Health Care Commission, which will make a final recommendation to the Sunset Committee. The Delaware General Assembly Joint Sunset Committee 1995 Final Report, dated May 31, 1995, recommended a comprehensive review of DIMER:

"The Committee continued the review of Delaware Institute for Medical Education and Research until 1996. This will allow the Health Care Commission Subcommittee on primary care, consisting of members of the Health Care Commission, Higher Education Commission, DIMER and others to review DIMER's purpose as it relates to the health care needs of all Delawareans; to examine the current training and higher education needs and opportunities for Delawareans in health care; to consider the ways in which Delaware's health care concerns, training and higher education needs can most efficiently and effectively be met by DIMER; and to consider DIMER's current activities in light of state needs and priorities."

This committee will address the health care needs of Delawareans, review the health care resources available in Delaware, identify medically underserved areas, and review DIMER's purpose, mandate, and function as it relates to the health care needs of all Delawareans. Specifically, the committee seeks answers to the following:

1. What is the purpose of DIMER? Should the purpose change to meet the health care needs of the present?
2. Should DIMER be continued as an alternate to a State-supported medical school?
3. Should its primary function be the recruitment and retention of primary care physicians?
4. Should its structure and function be changed to allow for the performance of both functions?
5. Should the scope of activity be changed to encompass the education of all Allied Health professionals as described in the primary charter?

Leslie Whitney MD
Executive Director

The report was filed with adoption of the Reference Committee's recommendation that the Medical Society of Delaware send letters of report of the original objectives of the DIMER program.

Delaware Medical Political Action Committee (DELPAC)

As of August 31, 1995, AMPAC membership was 48,685 which compared to 45,304 for 1994 and 46,112 for 1993. At that point, AMPAC membership was at 75 percent of its 1995 goal. State PACs should be at 85 percent of their individual goals by the end of August in order to meet their goals for 1995. As of September, 30, 1995 AMPAC membership was 51,364 and at that point AMPAC membership was at 79

Delaware Medical Political Action Committee (DELPAC)

percent of its 1995 goal. It was then ahead of year-end membership for 1994.

In 1993, Delaware had 79 members. In 1994, my first year as chairman, DELPAC attained 94 members and until August 31, 1995, we had 91 members with still two months to recruit members for 1995. I am glad to report that during the months of August, September and October there was a rapid increase in the membership thanks in great part to the personal effort of Martin G. Begley MD, and as of the moment that this report goes to print for publication in the House of Delegates handbook, the membership of DELPAC is 115.

Maryland, New Jersey, Kentucky, Mississippi and New York had met or exceeded their 1995 goals by the end of September, while last year only four states had reached their goals by year end. AMPAC anticipates that several more states will meet their goal by December 1995. Noteworthy is the fact that December 15 is the cut-off date for 1995 memberships. However, AMPAC and DELPAC have already begun efforts for the 1996 AMPAC membership year.

Thirty states had attained better than 60 percent of their 1995 goals by the end of August 1995. Eighteen states had attained 80 percent or better of their goals by the end of August. Eleven states had attained a desirable 85 percent of their goals by the end of August. In Maryland the increase was astonishing. They had gone from only 128 members in 1993 to 1,048 in 1994, to 1,133 members by the end of August 1995.

I have met with people from AMPAC a number of times. My own analysis of this situation is that the lack of political involvement and savvy on the part of physicians is pathetic. In talking with physicians, one of the problems seems to be their dislike

of Political Action Committees. I have repeatedly explained that I do not like Political Action Committees either, but they are the only game in town.

It is absolutely necessary to do something with our Congressional Delegation and the members of our legislature, or otherwise our capacity to influence important issues is going to disappear. I hope that the chairs of all the committees of the Medical Society and the members present at the House of Delegates will voice this concern among our membership.

Despite my frustration in trying to politicize our colleagues, I have found that the situation is not significantly better anywhere else. No matter how you look at the statistics, only approximately 10 percent of the physicians nationwide pay attention to this crucial aspect of our capacity to intervene in the governmental process and the election of legislators who are friendly to medicine.

I have enjoyed my second year as chair of DELPAC, nevertheless, and have enjoyed particularly the enthusiasm shown by its Board of Directors, especially our newest member of the board, Dr Begley. Dr. Begley has gone on a personal crusade to engage interest within Kent County physicians and has been successful in his crusade. If 10 other members of our society will make a similar effort, we could have a record membership for the forthcoming election year of 1996. I hope that everyone who reads this report makes a personal effort to recruit six members.

We have received a letter from AMPAC congratulating the Board of Directors of DELPAC for attaining 100 percent AMPAC membership of the Delaware Delegation to the AMA House of Delegates. It states, "Your commitment and determination to show solidarity within the Delegation deserves our applause."



Michael J. Bradley DO honored past MSD president, Thomas Maxwell MD with a certificate.

Thanks again to all of those who have contributed and my special thanks to Drs. Bradley and Begley, Mr. Mark Meister, and Mrs. Beverly Dieffenbach, who have been the champions of this cause and have helped me throughout these two years of hard work for our Political Action Committee.

Jorge A. Pereira-Ogan MD
Chair

The report was filed with a strong recommendation of physician support of DELPAC.

Legislative Specialist

The first session of the 138th General Assembly ended in the early morning hours of July 1, 1995, without fanfare, without final deals being made pertaining to all of the money bills, and without any compromises on key legislation. In fact, everything was downright boring, compared to previous years.

The session started off with the Governor proposing a tax cut package of approximately \$28.0 million. The Senate promptly passed this package in January and sent it to the House, where it was locked in committee.

What ultimately passed was a personal income tax reduction effective January 1, 1996, from the top rate of 7.7 percent to 7.1 percent; a personal tax credit of \$100 per exemption to replace the current \$1,200 deduction; and removal from the tax rolls of lower income earners. If future revenues are increased, the top rate will be reduced to 6.9 percent January 1, 1997 (HJR 17).

Total spending:	
Bond Bill	
(Capital Project)	\$223,600,000
Operating Budget	\$1,854,400,000
Grants-in-Aid	\$23,400,000
Transportation	\$168,200,000
Trust Fund	
Twenty-First-Century	
Fund-Escheat Tax	
Settlement from	
New York	108,700,000
	\$ 2,378,300,000

Although it was felt that Health Care Reform would take a new look in 1995, that was not the case. Congress was busy with the "Contract For America" and other "important" issues, so health care reform never made it to the forefront. The key issue at this time is a GOP plan to balance the budget by year 2002. In order to accomplish this, on-going programs would have to take substantial cuts. Included in this are Medicare and Medicaid. The President has stated he will veto any bill that cuts Medicare and Medicaid, as it would harm the middle class and elderly, and is taking to the airways to get his point across. The GOP says these are not cuts, just the slowing of the growth rate, and that the President is scaring the American people. The debate continues.

In Delaware, no sweeping reform was initiated. However, some key legislation pertaining to health care was introduced and passed. Of importance are:

- **SB 72** (Bair/McBride) - Later became SS1 for SB 72, relating to advance health-care directives. The Society supported this bill with a surrogate provision. The Senate passed this bill and it is currently in the House.
- **HB 124** (DiPinto) - Introduced by the Society, HB 124 will provide immunity for physicians and nurses who volunteer services for persons without insurance (DiPinto). The bill will be debated in January 1996. There is strong opposition from the trial lawyers.
- **HB 321** (Maroney) - The Fairness and Choice under Health Benefits Plans (Maroney). This bill, which was introduced late in the session, was drafted by the Society.
- **HB 340** (Maroney) - To provide parity of health insurance benefits for mental and physical illness.

Legislative Specialist

- **HB57** (Oberle) - To require bicycle riders under age 16 to wear safety helmets. Signed by the Governor.
- **HB 259** (Oberle) - To regulate optometrists' prescriptive authority under the Board of Medical Practice.

These are just some of the health-related issues the Society has been involved with. If there are any particular bills that are of interest to you, please call the Society.

The Society will be meeting with legislators from both the House and Senate for in-depth discussion of the legislative priorities that we feel are most important. These meetings will take place prior to the second session that begins Tuesday, January 9, 1996.

Philip J. Corrozi
Legislative Specialist

The report was filed with recognition of the outstanding efforts of Mr. Philip Corrozi.

Medical Society of Delaware Alliance

The Medical Society of Delaware Alliance is an active service organization for spouses which raises funds for national, state and local community projects, while providing fellowship and educational opportunities for members. Last year the DSMSA raised \$6,934.73 for the American Medical Association Education Research Foundation (AMA-ERF), which included \$5,934.73, for the Delaware Institute for Medical Education and Research (DIMER). Approximately 150 spouses joined this past year. Although our membership campaign coincides with that of the Medical Society, our AMAA year extends from May to May. For the coming membership campaign, we will improve our recruitment in each county, hoping to reorganize in Kent. Last

year, Delaware received national recognition for an increase in membership.

This year, the AMAA asked each state to set aside the second Wednesday in October to Stop America's Violence Everywhere (SAVE). In Delaware, a gubernatorial proclamation designating October 11 as SAVE Day was signed on the Green in Dover. Lt. Governor Minner and Attorney General Brady addressed participants. Alliance members then distributed certificates of recognition to agencies which work daily with Delaware victims of violence. In addition, Alliance members announced a Seven Point Program that will continue for the year. Many volunteers will be needed to make this program a success. In accordance with the AMAA, the Alliance is also selling SAVE lapel pins for \$10 each to support AMA-ERF. Chairman Linda Panzer is coordinating this effort.

On a state level, community health projects this year will involve the purchase of AMAA curriculum materials for distribution to public schools. This project will be funded in part by the sale of cotton shirts designed by members Mary Colbourn, Goldie Klein, and Linda Panzer. It is hoped members will wear the shirts when participating in sporting events. The shirts help publicize the many projects of the DSMSA. Also, other funding sources will be sought to pay for the curriculum material.

Legislative activities will continue under the guidance of Marianne Cameron and Anne Smith. Plans include get-togethers for legislators and spouses in each county. A new "hotline" for sharing legislative information is being developed by Marianne. Last spring, three members attended an AMA Legislative Workshop in Washington, D.C.

Various activities and fund

Medical Society of Delaware Alliance

raisers were held last year in the two organized counties. In New Castle, the Annual Wine Tasting raised over \$5,000 for the Perinatal Association. In Sussex County, over \$4,000 profit from a fashion show was donated to domestic violence prevention programs. For 1995-96, Joan Fiss, New Castle County President; Lyzbeth Arellano, Kent County president-elect; and Jackie Sopa, Sussex County president, have been working on the local level to increase membership and fellowship. New Castle has dedicated this year to the Medical Family. At the first meeting, Dr. Carol Tavani, President-Elect of the MSD, spoke on coping with stress in the medical family. Programs planned for the future include the Annual New Castle County Wine Tasting on February 23, and a Sussex County Fashion Show in March. Lyzbeth, Jackie and Marianne Cameron (president-elect for New Castle) attended the Confluence in Chicago during October.

In the spring, Jane Frelick and Mardy Dobson were given Distinguished Service Awards to recognize their many years of dedicated and creative service. In the words of Mardy Dobson, a former slogan still rings true, "Join us, together we can do more."

Roberta D. Chabalko
President

The report was filed with commendation for the Alliance for all their hard work in fund-raising and promoting medicine.

Medical Society of Delaware Insurance Services (MSDIS)

The 1994 report noted, "Two far-reaching and perhaps the most significant efforts undertaken since the founding of MSDIS began at the end of the fiscal year." Therefore, it is appropriate

to begin this report by revealing the outcome of these "... most significant efforts" In October 1994, a joint venture arrangement was instituted with RTA Financial Services, Inc., from which developed the Health Select Program of multi-choice, comprehensive health insurance coverage.

In February 1995, another joint venture arrangement was established with the Harry David Zutz Insurance Agency and their subsidiary, Zutz PLI, that in addition to complementing the insurance products already carried by MSDIS, further supplemented MSDIS to permit the sale of all possible insurance products of interest to physicians. Gains were also noted in "office packages," worker's compensation, home, automobile, life and the like.

The Health Select program of the joint venture with RTA has likewise been a rousing success, with over 900 physicians, their families and employees now holding health insurance through MSDIS.

Other notable activities for 1995 include the amending of the Certificate of Incorporation to permit the authorization to establish one or more classes or series of stock. The potential in this action is the possibility of sharing dividends with other professional groups that may want to establish an MSDIS-like insurance program.

Also, MSDIS established a free notary service to MSDIS insureds; formally changed the fiscal year to coincide with that of the Medical Society; improved the commissions paid by PHICO along with negotiating enhanced coverage for their medical liability insureds, as well as taking some credit for their 1995 rate decreases; developed and implemented a formal marketing plan, attempted to establish a formal relationship with Preferred Physicians Insur-

**Medical Society of
Delaware Insurance
Services (MSDIS)**

ance Company (PPIC); began meetings with the New Jersey Medical Society as to the availability of the MIIX Program in Delaware; implemented an enhanced Workmen's Compensation package; and, of course, continued the usual day-to-day activities of an insurance company, including several presentations to groups of physicians.

For 1996, the emphasis will continue to be on growth. Marketing efforts will be increased, and specific attention will be placed in order to gain greater recognition and participation of Delaware physicians in MSDIS. The similar objectives achieved during this past year, as noted, have been met by the vote of confidence provided to MSDIS by the Board of Trustees in their resolution of thanks and appreciation to the Board of Directors. For these efforts to be maintained and enhanced, and greater financial stability to the Society to become a reality, however, *it is important that all members of the Society participate with MSDIS for their insurance programs.*

A further special commendation is due to the MSDIS board members for their dedication to this most time-consuming voluntary responsibility for the Medical Society of Delaware. In addition, special thanks and appreciation must be afforded to Larry Zutz and Frank Wharton of Zutz Insurance and to Mike Taylor and Kent Evans of RTA for their enthusiasm and efforts on behalf of MSDIS and the Society. Special commendation is particularly due to Ms. Karen Reuschlein for her continued extraordinary service to the physicians of Delaware.

William H. Duncan MD
President

The report was filed with special commendation to Dr. Duncan for his devoted and enthusiastic service.

Physicians

Emeritus Delaware

There are approximately 300 physicians who are either retired or over the age of 65 who qualify as a physician emeritus. We meet three times a year, in October, January and April, for luncheon, fellowship and a speaker of medical, cultural or political interest.

In the past year, Donald L. Kjelleren spoke about his "Great American Odyssey," during which he visited the capitol and highest point of each American state. Representative Jane Maroney addressed the group last year prior to her unopposed election. In April, a business meeting was held and John M. Levinson MD was appointed Chairman of the Nominating Committee. His committee selected Davis Durham MD for the next President and George Henderson MD as the next Vice President.

The format of the meetings was changed slightly. Meetings are held on the third Tuesday of October, January and April, and start with fellowship at 11:30 a.m., lunch at noon, to be followed by the speaker.

George Henderson presented a fascinating review of the process involved in sculpturing in bronze, which was greatly appreciated.

As retiring President, I wish to thank all the members of the group, especially Mrs. Mary LaJudice of the Medical Society of Delaware, without whose efficiency this organization could not exist.

Howard D. Cohen MD
President

The report was filed.

The Delaware Trustee, West Virginia Medical Institute

This year the West Virginia Medical Institute is in the midst of their current three-year contact cycle for Medicare review in

Physicians Emeritus Delaware



As 1995 MSD President Michael J. Bradley DO passed the torch to the new President, Carol A. Tavani MD, he presented her with a special gift of his own to assist her in her presidency.

**The Delaware Trustee
West Virginia
Medical Institute**

Delaware. This scope of work is quite different from what the PROs have done in the past. With the exception of quality improvement projects, the only time the PROs will scrutinize specific charts is when there is a patent dumping complaint, a beneficiary complaint, a hospital request for a DRG change, requests for assistants at cataract surgeries, and notices of non-coverage to beneficiaries issued by hospitals and managed care plans. Random chart reviews for DRG validation and reviews of charts that failed generic screens have ended. Along these lines, the Uniform Clinical Data Set (UCDS) which HCFA recently developed has been terminated. This was a method of chart abstraction that had many elements, and its complexity made chart abstraction long, intensive and quite expensive.

Replacing generic screen and random chart review is what HCFA has dubbed the Health Care Quality Improvement Program (HCQIP). Here the emphasis is on looking at critical pathways, encouraging best practice patterns, comparing institutions with each other, and analyzing variations between regions and hospitals. Institutions would receive information on how they compared over all with other like organizations. It would then be up to the individual hospital to analyze its particular situation and implement appropriate changes. Each PRO is required to conduct between four and 18 such studies per year. In Delaware, these projects include patterns of blood usage, the prescribing of pre-operative antibiotics, the treatment of community acquired pneumonia, utilizing breast conservation surgery as opposed to a mastectomy, the INR initiative, the prevention of CVAs in chronic atrial fibrillation patients, and patterns of mammography utilization. Under the old system of

"quality assurance," for example, your care for a pneumonia patient might be questioned if there was a poor outcome such as an unexpected return to the intensive care unit or a neurological deficit at the time of discharge that was not present on admission. With the HCQIP, care is deemed appropriate if the critical pathways are met, e.g., pretreatment sputum cultures when possible, the prompt administration of antibiotics. The goal of this type of review is to move the treatment of a whole patient group toward better care as opposed to focusing on just one case. Because of the pneumonia study, one hospital changed its admission policies so that antibiotics will be given in the ER as opposed to the floor. Experience is showing that these studies are much more productive and less confrontational than just looking at generic screens and focusing on the individual case or patient.

The PROs had their annual meetings in September, and two themes came to the forefront. The emphasis will continue to be looking at patterns, outcomes and variations rather than specific physicians and events. Secondly, there will be an explosive growth in the percentage of Medicare and Medicaid patients in capitated plans. As more risk contracts are awarded, the PROs will be spending more of their time in evaluating this type of managed care. New practice guidelines will focus not just on inpatient care, but rather on how an integrated system takes care of all patient functions. Preventive medicine, acute office-based care, hospitalization, and how patients are rehabilitated and returned to a productive life will be evaluated as a continuum. These guidelines should stress well-accepted clinical patterns of care and be easily measured. There will be extensive profiling, and patterns of care and costs at one institution will be

compared to that of others. Outcomes will be stressed as opposed to individual cases. The goal will be to profile systems that achieve the best results at the lowest price.

The future will be challenging and the pace of change will accelerate. The next several years will be exciting ones!

Brett Elliott MD
Trustee, WVMI

The report was filed.

Reports of Advisory Councils

Advisory Council on Cancer Control, Division of Public Health

The Advisory Council on Cancer Control's membership currently includes representatives from several public and private agencies and has the responsibility of advising the Division of Public Health on issues involving cancer monitoring and prevention. A significant undertaking of the Advisory Council over the last year was development of the process and methods for implementing and tracking progress toward meeting the recommendations of the Governor's Task Force Report on Cancer in Delaware. Four subcommittees were established under the aegis of the Advisory Council to address elements of tobacco use prevention, public education and policy, environmental evaluation and monitoring, and outreach to the medically underserved. The four subcommittees each have met one or more times and are scheduled to present their preliminary reports in January 1996.

The Advisory Council on Cancer Control has worked with the Division of Public Health to begin planning and implementing activities funded under two of their federal grants. The Tobacco Con-

trol grant and the Breast and Cervical Cancer grant were both funded by the Center for Disease Control for planning during the last year. The Tobacco Control grant moved into the implementation phase in October of this year; however, the Breast and Cervical Cancer grant will have one more year before screening implementation. Several members of the Advisory Council participated in a two-day retreat for the Breast and Cervical Cancer grant's strategic process. Council members are also supporting efforts of the Tobacco Control Coalition's efforts in developing a statewide plan for tobacco control.

Leslie Whitney MD
Liaison

The report was filed.

AIDS Advisory Task Force

The AIDS Advisory Task Force submitted its report to the Governor and then disbanded.

A new AIDS Consortium is forming to help establish policy regarding AIDS in the State of Delaware. I have agreed to serve as a consultant to that new Consortium on issues as they arise.

Marshall T. Williams MD, PhD
Liaison

The report was filed.

Controlled Substance Advisory Committee

The Medical Examiner's office reports a 44-day turnaround for drug analyses on materials obtained by the M.E. In the future, we can expect turnaround time of 14 days.

The report of the Bureau of Alcoholism and Drug Abuse by Doctor Mario Pazzaglini warned parents concerning LSD tattoos, told of "Amino Acids and their Effects," reported an ad for a four-hour heroin detoxification clinic, a

**Advisory Council
on Cancer Control,
Division of Public
Health**

**AIDS Advisory
Task Force**

Controlled Substance Advisory Committee

Toyota advertisement containing the words "Shake," "yearned for a substance," and "ready to rock," which are code words for cocaine among the white collar workers, and drug abuse statistics from Medlab Clinical Testing.

Chief Agent Paul Davis of O.N.D.D. reported forgeries on the increase with the drugs involved being Percocet, Darvocet, and Vicodin.

The Counterdrug Technology Assessment Center (CTAC) was created by Counterdrug Technology Act of 1990 (Public Law 101-510). At this time CTAC scientists are learning how cocaine consumption is reinforced and ultimately becomes addictive. CTAC hopes to someday immunize addicts from the effects of cocaine. It is hoped catalytic antibodies can be directed against cocaine, would hydrolyze and deactivate cocaine and thus would free them for further bonding.

The following case study (from *Emergency*, June 1995) supports the arguments for controlled prescriptions for steroids.

Steroid abuse caused cardiac arrest

A case study documented the instance of a cardiac arrest that occurred in a 20-year-old amateur bodybuilder who was using steroids. The patient was a 220-pound, five feet ten inch-tall male who had been self-administering the drugs.

He did not have either a prior history of cardiac disease or family medical history of cardiac problems. He had recently concluded a three-month cycle of several anabolic steroids obtained in Mexico.

The steroids that patient was using were anabolic steroids, the usual kind and dose that individuals in the bodybuilding community use.

Witnesses at the scene of his cardiac arrest reported the patient collapsed suddenly, his bladder emptied and Cheyne-

Stokes respirations ensued. The patient was transported by advanced life support to a county hospital where resuscitation attempts failed. At autopsy his heart was noted to weigh 515 grams. A normal heart weighs about 250 grams.

Street drugs are rarely a single drug anymore. In use a single drug will have a second or third drug added to increase the high, decrease nausea, intensify hallucinations, add sedation, and block sedation. All this should alert us to look for more than one toxic drug in both the acute and chronic patient.

The following material from Dr. Pazzagli of the Bureau of Alcoholism and Drug Abuse is included for your information.

"Drugs Added to Drugs"

"Oftentimes street drugs are altered with the addition of other drugs. There are usually two reasons for this. One is to change or enhance the effects of the main drug usually with knowledge of what to expect. The second is to add ingredients to a drug because the base drug is considered weak or of poor quality. In the latter case the consumer is often duped into thinking or feeling that they are getting 'good stuff.'"

"An example of the first case happens when strychnine is added in *small* amounts to LSD in order to enhance its effects. An example of the second type is seen when PCP is added to poor quality marijuana to give it a greater "punch" or effect. Often the base marijuana is of extremely poor quality and at times may not be marijuana at all but some plant substitute like oregano or parsley.

"Many of these combinations are experimental and some are marketing schemes. Mixtures like these are becoming more common."

Rhoslyn J. Bishoff MD
Liaison

The report was filed.

Diabetes Advisory Council, Division of Public Health

The Diabetes Advisory Council has not been as active this year; only three meetings were held.

- The Diabetes Resource Guide is being updated and will be published as a second edition in about six months.
- The Diabetes Registry for children with IDDM originally considered ISIS as its vehicle for tracking, but with the limitations identified, we are now gathering information to establish our own tracking program.
- We want to support legislation on discontinuing the "pre-existing" condition clause that some insurance companies utilize. In the context of diabetes this eliminates coverage for six months to two years in most cases.
- We are looking into supporting or initiating legislation regarding safe disposal of hazardous waste as it pertains to diabetes supplies, syringes, strips and lancets.

Our major setback is not having working capital to initiate any of these projects. We have not pursued grants or legislative sources as yet, but we are considering a few avenues at this time.

Charles Laudadio MD
Liaison

The report was filed.

Domestic Violence Coordinating Council

This report is taken from the Second Annual Report from the Delaware Domestic Violence Coordinating Council to the Honorable Thomas R. Carper, Governor of Delaware, and to the Honorable E. Norman Veasey, Chief Justice of Delaware's Supreme Court. The complete report is on file in the office of the State Medical Society.

Members of the Council are: Hon. Vincent J. Poppiti, Chair, Chief Judge Family Court; Hon. Patricia M. Blevins, Vice Chair, Delaware Senate; Dr. Anne C. Aldridge, Family Physician; Dr. Rhoslyn J. Bishoff, Commission on Family Law; Cynthia M. Boehmer, Program Director, Families in Transition, People's Place; Hon. M. Jane Brady, Attorney General; Hon. Deborah H. Capano, Delaware House of Representatives; Mary W. Davis, Chair, Domestic Violence Task Force; Colonel Thomas P. Gordon, New Castle County Police; Hon. Karen L. Johnson, Secretary of Public Safety; and Hon. Lawrence M. Sullivan, Public Defender. Raina H. Fishbane, Esq., serves as executive director. The executive director position is full-time, and her salary is currently being paid by the Family Court. The Council is required to meet four times a year and meetings are open to the public. As noted in the Foreword of the Annual Report:

"In the past year, the Domestic Violence Coordinating Council has accomplished a lot and is currently working on a number of very significant projects. There is, however, much more work that is needed. Domestic violence is still too common through the state. The number of domestic violence related deaths is skyrocketing and the overall number of domestic violence incidents has steadily increased.

"Delaware has the opportunity to create, implement and promote a truly integrated and coordinated response to the problem of domestic violence that could serve as a national model. Most importantly, Delaware is in the position to help save individuals from experiencing the physical and emotional suffering, and even loss of life, caused by domestic violence. We hope that the Coordinating Council has contributed and will continue to contribute to this cause."

Diabetes Advisory Council, Division of Public Health

Domestic Violence Coordinating Council



Dr. Bradley's family gathered to join him in celebrating his 1995 presidency.

Homicides as far as recorded at the time of the Annual Report are listed in the attachment. The severe damage to society can only be imagined by reading the news reports of these homicides. The other damage to society of now yesterday and the future from violence without homicide cannot be tabulated in Delaware or the other 49 states and Washington, D.C.

The Council is responsible for: 1) studying court services and procedures relating to domestic violence; 2) studying law enforcement procedures and protocol; 3) reviewing criminal justice data collection and analysis as it relates to domestic violence; 4) effectuating coordination between all relevant agencies, organizations and the courts; 5) promoting effective prevention, intervention and treatment techniques; and 6) recommending standards for treatment programs to the Department of Health and Social Services, Department of Services for Children, Youth and Their Families, Department of Corrections and other service providers.

To accomplish these goals, the Council has created an executive committee and 11 standing subcommittees that are chaired by members of the Council and that include other members of the community. The Council's executive committee is comprised of the Chair, Vice Chair, and three other members of the Council. Mary Davis, Colonel Gordon and Dr. Bishoff serve on the Executive Committee, along with Chief Judge Poppiti and Senator Blevins.

The Annual Report summarizes activities in the following areas: Court Conference, Domestic Violence Awareness Month, Legislation, Supervised Visitation Centers Report, Participation in Police Chiefs Conference, Public Appearances, Training, Pro Bono Attorneys, formation of Finance Committee, Information Clearing-

house, Public Forums, and Media Activities.

The Council has established the following goals as critical to reducing the incidence of domestic violence:

Completion of

Statewide Assessment

- **Education** - community education about the dynamics and incidence of domestic violence; education in public and private schools (from grade school through high school) to teach children about domestic violence, help them if they have experienced violence in their homes, and teach them non-violent relationship skills; education in public and private schools (including colleges and universities) about dating violence; education of individuals who deal with victims of domestic violence; informational pamphlets created by the Council should continue to be circulated in a wide range of public areas, such as grocery stores, government offices, shopping centers and physicians' offices; and create a pamphlet describing the Protection from Abuse Act.
- **Statistics**- Comprehensive and up-to-date statistics, including criminal and civil cases, must be maintained for a broad range of domestic violence offenses.
- **Legislation**- Enactment of legislation removing the voluntary social companion exception from the current rape laws and legislation to protect the confidentiality of a victim's address maintained in Motor Vehicle and voter registration records.
- **Law Enforcement**- Mandatory reporting should be required by each of the police departments; all officers should participate in annual training on domestic violence; and each police agency should adopt the model domestic violence policy developed by the Council.

- **Medical Community-** Finalize model protocol for evaluating and treating victims of domestic violence; train all health care professionals about domestic violence; train all health care professionals about domestic violence, including training about the use of protocols.
- **Treatment and Resources-** Assess treatment services now available and develop treatment models and protocols that could be used by treatment providers; develop a comprehensive list of statewide resources.
- **Prevention and Intervention Programs-** Help implement supervised visitation centers and expand network of *pro bono* attorneys who would represent victims of domestic violence.
- **Court Services-** Implement follow-up training for judicial officers and court staff and promote the use of victim advocates to ease the judicial process for victims of domestic violence.

The council believes that one of the State's overriding goals must be to protect children from being victims of domestic violence. Shielding children from violence in the home may in the end be the only way to prevent domestic violence from occurring in the future. The Coordinating Council has received support from private companies, but in order to fulfill its goals it needs to receive additional funding directly from the State.

Rhoslyn J. Bishoff MD
Liaison

The report was filed.

Drug Free Schools and Communities Committee

Through the last six committee meetings tobacco has been a prominent target. It has been noted that spotting children with

a tobacco habit has served as an entree to obtain such children as customers for drugs — first marijuana, followed by harder drugs.

It was announced that R.J. Reynolds, in agreement with the Junior Chamber of Commerce, was mounting an advertisement campaign against the selling of tobacco products to minors. Do you recall the story of the "Trojan Horse?" Did you see last year's *Consumer Guide's* portrayal of gifts to children if they collected coupons of tobacco products including snuff and chewing tobacco. The Greek's Trojan horse still demands awareness.

The following is a paraphrasing of an article in the *Journal of the American Medical Association* (1993) which identified cigarette smoking as the real leading cause of death in the United States. At least 400,000 people die annually because of cigarette smoking, more than the total deaths from AIDS, alcohol and other drugs.

We do not argue with the right of an adult to choose to smoke. However, we do believe that we as a society have an obligation to keep tobacco products out of the hands of minors (children and adolescents). It is obvious that the tobacco advertisements have relentlessly targeted our young people as a market to replace the 1,100 smokers who die each day. Ads of Camel and Marlboro are good examples. Given the addictive nature of nicotine, shouldn't we try to delay the start of smoking at least until the age of majority?

A student survey of grades 5, 8 and 11 is almost complete and should be official by our November meeting.

Title IV funding is at this writing unknown.

It is obvious that many committees, private organizations and government agencies need a collaborating overall function.

**Drug Free Schools
and Communities
Committee (DFSCC)**

Monies and time would be best used if a coordinating group would function to the benefit of all.

Workshops are again planned for this fall.

A statewide conference is planned in conjunction with the YMCA which will help to reduce expenses for both DFSCC and YMCA as one of the first fully collaborating functions of our DFSCC.

Life Lesson Series was purchased for distribution in K-4 schools through the financial support of DPI/DFSCA. Sixty percent of the teachers and guidance counselors used the Life Lesson Series. Eighty percent of those who were contacted used the material found results effective and 100 percent planned to use the video next year.

Rhoslyn J. Bishoff MD
Liaison

Family Law Commission

Family Law Commission

The Commission on December 1, 1994, was able to point out as accomplishments for the Court and the public the following General Assembly bills that are now law that were on the Commission's agenda: HB 288, parental notification in cases of abortion; SB 334, wage attachments to cover health insurance premiums; SB 351, child custody and visitation in case of violence.

What the Commission has done for the Courts and the public lately makes up the remainder of the report.

Complaints of payors have brought the suggestion of an agreement or legislation to have quarterly reports to the payor to help him or her be aware of his or her financial status obligations.

Arguments to support an advocacy group for better means of collecting child support by means of concentrating on use of cautions, better scheduling, pursuing contempt of court and enforcing court

directives were entertained from a report of the activities of Ms. Donna King by Ms. Barbara Corrozi, Executive Assistant for Child Support.

Views on adoption were heard by the Commission from Ms. Barbara Crowell, Chair of Family Law Section of the Delaware Bar Association. Judge J. Jones was assigned to work on this with Ms. Crowell.

A conference was held in Georgetown with the cooperation of Ms. L. Cooper and Mr. J. Moening, both members of the commission.

Heard at the May 18, 1995, meeting were M. Stevenson, Phyllis Witcher on "No Fault Divorce" and Attorney General Jane Brady on "Child Abuse." Ms. Witcher spoke for the rights of both parties in our divorce laws with accountability for economic custody issues.

Attorney General Brady admits her commitment to decreasing, while working toward eliminating, child abuse. She made the following proposals:

- Child Abuse Murder Legislation.
- Required training for those in the Attorney General's office when working in child abuse.
- Enhancement of penalties if child is under 14.
- Pre-sentence report on family before court order is determined.
- Children's trust fund to assist more.
- Legislation pending to increase amount of monies.
- Meeting with Medical Center Director to initiate more learning to ER staff.
- Program to have fewer "interviews."
- Program for criminally-involved children.
- Training session for Family Court prosecutors.
- DWI legislation for offenders with child in car.

The Family Law Commission will continue its work with the first meeting of its working year on November 1, 1995, at Buena Vista.

Rhoslyn J. Bishoff MD
Liaison

The report was filed.

Medical Care Advisory Committee, The Division of Social Services

It is my privilege to report to you the progress of the Medical Care Advisory Committee (MCAC) for the past year.

The MCAC is based in federal regulation and the members are appointed by the Secretary of the Delaware Department of Health and Social Services (DHSS). The MCAC has been meeting approximately every three months during the past year. The MCAC consists of representatives from the fields of medicine, consumer groups, other appropriate groups and from the DHSS' Medicaid Program, all of whom advise the Medicaid Program about health and medical care services. The chairperson of the MCAC is Dr. Anne Aldridge.

The MCAC has an ongoing role of working with the DHSS and the Medicaid program by contributing knowledge, providing a channel of communication, studying and making recommendations, working with other advisory committees, advising on alternate health systems and other means to maximize resources. The specific activities of the MCAC this year included:

- Working with Medicaid in anticipation of the managed care program to be established by Medicaid in January 1996. The managed care program is administered by Kay Holmes.
- Following the progress of the Delaware Health Care Commission by receiving regular reports from the HCC.
- Monitoring the progress of the Society's VIP program through

regular reports by Mark A. Meister, Executive Director of the Medical Society of Delaware and a member of the MCAC. Assisting Mr. Meister is Dr. James Gill, who has been following the program for statistical analysis.

- Following the development of the Nemours Foundation Pediatric Clinics. We are assisted on this matter by Dr. Steven Dowshen from A. I. DuPont Institute.
- Looking at an educational effort aimed toward Medicaid recipients in effective use of the program.
- Working with Medicaid on developing a Case Advisory Committee for evaluation of services to technologically dependent patients and services for patients with extraordinary needs, i.e. transplants, etc.
- Receiving overview reports on various Medicaid and Social Service functions such as the Smart Start Program and the Drug Utilization Program.

In summary, it is my opinion that the MCAC has developed as a strong resource for both the provider community, as well as the Division of Social Service. The ability to communicate freely on a regular basis, as well as look at developments in medicine, are serving both the providers and the state of Delaware with an excellent opportunity to monitor, as well as effect change in the health care of our citizens.

Thank you for this opportunity to provide information to the Medical Society on behalf of this very worthwhile committee.

Edward R. Sobel DO
Liaison

The report was filed.

State School Health Advisory Committee

Physicians have lost contact as medical care givers in health care areas. Now, nurses are having the

Medical Care Advisory Committee, The Division of Social Services

same problem. School nurses have lost to school principals the right to exercise decisions concerning children while on school field trips. This decision for principals take-over is to be appealed at a high Delaware State Authority. Physicians used to aid in solving these problems.

The State School Health Advisory Committee (SSHAC) has struggled from September 29, 1994, to its most recent meeting on September 27, 1995, with slow but ever-increasing beneficial results (except field trip health care) in the following concerns:

- **Tuberculosis Project** — the course of action advised is to do Mantoux skin tests (see attachment). Only Mantoux skin tests; no other will suffice. If a physician or health clinic does not have the guidelines, contact either Edith Vincent of the Department of Public Instruction or Kathleen Russell of the Division of Public Health and request the communication of August 23, 1995, entitled "Important Alert."
- **Medication on Field Trips** - see the introductory paragraph of this report.
- **Overview of Parent Education Programs** - Child, Inc., reviews with parents who are interested the problems of divorce. The courses offered by Child, Inc., are voluntary. There is in these courses great concern and teaching offered in children of all ages' reaction to separation.
- **Youth Risk Behavior** - this is best understood when the Risk Behavior Survey Results are reviewed (see attachment).
- **Athletic Physical Forms** - this was hashed and rehashed through five of the SSHAC's last six meetings. Each school nurse and all athletic directors should have physical forms to qualify all athletes before they start training in the sport for which they qualify.

- **State's Collaborative Assessment and Student Standards** - was reported to the committee on September 19, 1994, and May 11, 1995. The following is verbatim from that report from Janet Arns:

"Highlights include: This is the second year of the project with 30 states participating under the direction of the Council of Chief State School Officers. The primary purpose is to develop and validate a variety of assessment materials which are appropriate for use in large-scale assessments of health education at the elementary/junior high/middle and high school levels to determine student status relative to emerging student standards as well as assessments for use by teachers. Six areas of adolescent risk behavior identified through the Youth Risk Behavior Survey (YRBS) conducted by CDC constitute another component of the assessment development framework. Four of these areas — Alcohol and other Drug Use Prevention, Nutrition and Dietary Behavior, Physical Activity Promotion and Tobacco Use Prevention — were the focus of item tryouts during the past spring. Elementary and high school teachers from Christiana were involved in this pilot project. Additional tryouts are scheduled for the fall of 1995."

- **Do Not Resuscitate** — was discussed at four of the six SSHAC meetings, and the problem is not yet satisfied. School Health Services Study is trying to learn the role of the school nurse in relating to the school-based wellness centers.
- **Sports Injuries** — are still an unsolved question. The comprehensive collection of data is not available.
- **The Nurses' (School Nurses) Handbook** — is still awaiting updated decisions on the nine foregoing subjects.

State School Health Advisory Committee

Presented in the last meeting on September 27, 1995, was an "Interagency Confidentiality Agreement for Accessibility and Data sharing Between Participating Organizations" (see attachment). A copy is being given to our Board of Trustees to review and comment to the authorities proposing this, since we all are asked to report to various departments of the Delaware state government.

Lastly, please read the history of the Delaware School Health Advisory Committee (see attachment) compiled and reported by J. Thomas Butler of Delaware State University.

Rhoslyn J. Bishoff MD
Liaison

The report was filed.

Governor's Planning and Advisory Council Division of Alcoholism, Drug Abuse, and Mental Health

For more than seven years, I have been the liaison for our Medical Society to this advisory council. I have served under three different administrations and have witnessed the growth of this council, which today is a powerful arm of government and one more way in which we can help shape the delivery of health care systems in our state. In 1991, Governor Castle appointed a task force which, under the masterful chairmanship of former Supreme Court Justice William Quillen, made sweeping changes in the mental health code. The corresponding legislation became law in July 1992.

In September of this year, Secretary Nazario formed a task force to study the effectiveness of alcohol and drug treatment services throughout the state. The task force operates under the chairmanship of Thomas M. Fritz, Director of the Division, and

includes members of the Departments of Health and Social Services; Justice; Corrections; Children, Youth and their Families; Public Instruction; and Public Safety. Also represented are New Castle, Kent and Sussex Counties, the Office of the Controller General, the University of Delaware, the Addictions Coalition of Delaware, the Public Defenders Office, Superior Court, the Criminal Justice Council, Family Court, the Budget Office, and the Advisory Council I represent.

The Advisory Council to the Division is composed of 17 members appointed by the Governor and 10 associate members appointed by the Council. In keeping with the streamlining of government objective of the Minner Commission, the Advisory Council merged with the Planning Council. With the Director of the Division and a facilitator lent by Governor Carper, the Council held a retreat at the Virden Center of the University of Delaware, Lewes Campus early in October 1995, and the Council has emerged stronger and more committed to its goals and with a total review of the Bylaws that govern its functions. The Council meets monthly and advises the Division, the Secretary and the legislature of its concerns, oversees the operation of the contractual providers of services in the state and plays a significant role in the shaping of the Governor's budget recommendations by testifying at the hearings of the Budget Office and the Joint Finance Committee. The Council hopes that its hard work will yield a greater cooperation between the public and private sectors and a better system of delivery of health care to all Delawareans.

Jorge A. Pereira-Ogan MD
Liaison

The report was filed.

Governor's Planning and Advisory Council



Carol A. Tavani MD presents the President's silver tray to Michael J. Bradley DO.

*Reports of Community
Health Organizations*

American Cancer Society, Delaware Division, Inc.

The 1994-95 year was one of reorganization for the American Cancer Society, Delaware Division, Inc. Having determined the priority activities that needed to be done to have the greatest impact on cancer control the year before, the division recognized the need to be organized to accomplish those goals. The Board of Directors has been redesigned around key cancer issues — tobacco control, breast and prostate cancer detection, comprehensive youth health education, patient services and information, volunteer and branch services and income development. Grassroots program delivery is done by regional interdisciplinary teams of volunteers in northern and southern Delaware. Local fundraising and volunteer recruitment activities are done by six volunteer driven branches.

The first non-profit organization in Delaware to be awarded the State Quality Award, the American Cancer Society has been diligent in continually improving the ratio of human and financial resources which are dedicated to grassroots cancer control. Recognizing that the division is the only statewide volunteer-driven, community-based cancer control organization in Delaware, we have accepted with great enthusiasm our responsibility to provide leadership in the war against tobacco. As the state with the highest mortality rate from cancer (after the District of Columbia) and the ninth highest smoking rate, there is much to be done; success will require the efforts of multiple private and public entities. The ACS has positioned its resources to lead the challenge.

Leslie Whitney MD
Liaison

The report was filed.

American Lung Association of Delaware

The American Lung Association of Delaware (ALAD) is involved in many areas that would be of interest to the Medical Society of Delaware; however, three core programs come to mind: asthma, tobacco control and clean air.

The ALAD is experiencing an increase in the number of Delawareans being diagnosed and treated for asthma. An increase in the number of asthma-related deaths is also being noted. To help educate Delawareans about asthma, several programs have been implemented. Family Asthma Day is for children ages 3 to 12 years old and their families. The program involves physicians, nurses, and respiratory therapists. A teen/young adult program is sponsored in conjunction with the American Academy of Allergy and Immunology/ Delaware Allergy Society. Open Airways, a school-based asthma education program, was implemented last year in several schools statewide. More training workshops are being planned for this year.

Tobacco control issues are in the forefront locally, as well as nationally. In Delaware, a Clean Indoor Air Act was passed in 1994 to limit an individual's exposure to environmental tobacco smoke in many public places. ALAD was instrumental in the public relations and education campaign regarding the Act.

In cooperation with the Medical Center of Delaware, the ALAD and other health agencies coordinated "Breathe Easy." Breathe Easy is a hospital-based education program for smokers. The program identifies smokers upon admission and alerts a trained Respiratory Therapist to make a visit with "Quit Smoking" literature, as well as other resources.

Tobacco advocacy is a major part of our Association efforts. Most recently, the ALAD has become involved in supporting the

**Reports of Community
Health Organizations**

President's bid for FDA to regulate tobacco products.

Statewide efforts continue to keep tobacco products out of the hands of young people. This is a part of a federal amendment attached to mental health grant monies. The state must conduct unannounced inspections at places with vending machines or places where tobacco products are sold. The inspections must use young people under 18 years of age. The ALAD has been involved in statewide inspections and will be part of the education process in the upcoming year.

As a member of the State Tobacco Coalition, IMPACT, the ALAD has taken on a leadership role to mobilize community groups in joining the fight against young people's easy access to tobacco.

The ALAD has always been champion of clean air issues. Efforts include keeping the Clean Air Act at its current strength, educating Delawareans about pollutants such as ozone, reporting the daily air quality reports for all three counties to the media, and mobilizing communities to fight for tighter emission controls on industry.

It is through these programs, along with many others, that the ALAD continues its efforts to fight lung disease. The programs have been made possible through the efforts of dedicated volunteers and the Delaware Thoracic Society, the medical arm of the American Lung Association. These individuals and groups have given countless hours of time and resources. We thank each and every one of you for your commitment to fighting lung disease. Remember — when you can't breathe, nothing else matters.

John J. Chabalko MD
Liaison

The report was filed.

Delaware Center for Wellness

The Delaware Center for Wellness is continuing to expand its activities within the business community. After having overcome an unfortunate loss of fiscal support from the Division of Public Health several years ago, the Center for Wellness, under the forceful leadership of Carol Soha, RN, PhD, has regrouped in the last two years. It now has a Board with good representation from the business community plus physicians, and has obtained several grants and promoted projects which have increased income to the point that additional staff has been added. Thus the Center now has a greater depth of resources for the working community it serves. Dr. Lieberman has played a central role to make this resource for prevention available to the working population of the state. The workplace provides access to the largest well population in the state, aside from those in the schools, who can be considered captive audiences for health promotion activities.

The Center is encouraging businesses to underwrite health risk surveys among their employees to identify those who would benefit from preventive interventions. Prevention in the workplace is not only helpful for employees but helps a business' bottom line. Physicians all too often only see patients after they have been injured or are sick and do not have an opportunity to interact with most of the "non-sick" population. Therefore, it is important that the medical profession maintains a good liaison with those promoting scientifically based prevention interventions. Many inadequately educated individuals have jumped on a band wagon to promote "prevention services" without scientifically based ideas. The Center for Wellness has no ground rules to

follow in terms of asking for qualified certification from many wishing to promote various aspects of Wellness to business and to the general public who have contacted the Center.

It might be appropriate for the Medical Society to propose to the AMA that it sponsor a study to determine if there is a need for certification of prevention specialists. Otherwise, "prevention services" are likely to fall into the hands of managed care "experts," most of whom give lip service to prevention without having a national body to certify who may or may not be qualified to provide such services.

Robert W. Frelick MD
Liaison

The report was filed.

Impact Delaware Tobacco Prevention Coalition

IMPACT Delaware Tobacco Prevention Coalition was formed in 1995 to address the need for a comprehensive approach to tobacco control and prevention. The Medical Society of Delaware has joined the broad-based coalition of health, family, and community groups spearheaded by state chapters of the American Lung Association, American Heart Association, and American Cancer Society. These groups have joined forces to develop a strategic plan that identifies priority areas and high-risk groups with regard to the health effects of tobacco. The IMPACT Coalition is committed to creating a healthier Delaware where fewer children become addicted to tobacco, fewer people are exposed to second-hand smoke, and tobacco users can find the resources they need to quit.

The five year goals of the Coalition are:

- To reduce to 20 percent the prevalence of cigarette smoking

among persons over 18 years of age.

- To reduce to 15 percent the number of youth under the age of 18 who use tobacco products.
- To eliminate second-hand smoke at all public places, thereby reducing passive exposure.

These goals will be achieved by targeting three specific groups:

- The smokers and those at risk for initiating smoking.
- Individuals who can affect policy changes, such as politicians, community leaders, and the media.
- Individuals who can amplify and extend effective smoking control, such as health care providers, youth advocates, and teachers.

These groups will be reached by programs implemented through community networks, work sites, schools, and health care systems. In this latter regard, physicians play a significant role. Each year, approximately 75 percent of adults visit a doctor at least once. Physicians, dentists, and other health care providers can be influential in a smoker's decision to quit. In a US survey of household, respondents cited physicians as the source of most of their health-related information, as well as the most reliable information. Seventy percent of smokers claim they would quit if the physician gave them unequivocal advice to do so. Studies confirm that many smokers have quit on advice from their physicians, particularly when the advice is combined with self-help handout materials.

A variety of state and national polls indicate that Delawareans favor increased restriction on tobacco use. Recent data suggests that tobacco use among youth is on the rise. Enactment and enforcement of laws restricting tobacco access to minors is critical to the long-term physical and economic health of Delaware. As

an affiliate member of the IMPACT Coalition, the Medical Society endorses the Coalition's mission to improve the quality of life for all Delawareans by reducing health risks related to tobacco use and exposure.

Albert A. Rizzo MD
Liaison

The report was filed.

March of Dimes

Birth Defects Foundation

The Health Professional Advisory Board, as well as the Executive Committee of the March of Dimes Birth Defects Foundation of Delaware and Upper Shore of Maryland, has spent much of 1995 concerned with the infant mortality issue in Delaware. The March of Dimes has worked closely with the *News Journal* as a participant in the Cradle of Hope symposium. Several Board members of the March of Dimes have served on the Steering Committee for the symposium. The March of Dimes has been working with other organizations in the State, including the Perinatal Association of Delaware, to support numerous infant mortality initiatives, including spending a great deal of time on the Resource Mother project. In addition, the local chapter has been encouraged to seek funding from the national level of the March of Dimes to obtain funding for a staff member devoted exclusively to the infant mortality issue.

Finally, the Health Professional Advisory Council is preparing for Genetics Week in Delaware under the supervision of its Chairman, Dr. Digamber Borgaonkar. Genetics Week will be held from March 18, 1996, through March 23, 1996, at sites throughout Delaware and in Cecil County, Maryland.

Garrett H. C. Colmorgen MD
Liaison

The report was filed.

Memorial

As a memorial to the members of the Society who were lost through death during the past year, the assembly rose for a moment of silence as the following names were read:

John C. Bradford, Sr. DO
Robert S. Brennan MD
Phyllis D. Gallaher MD
Elmer R. Gross MD
William O. LaMotte, Jr. MD
Douglas W. MacKelcan MD
John W. Maroney MD
Peter J. Olivere, Sr. MD
Richard W. Skinner MD
Harold P. Sortman MD

Absolution Resolution

The House adopted the following resolution:

RESOLVED, That each and all of the Resolutions, acts, and proceedings of the Board of Trustees of the Medical Society of Delaware heretofore had been adopted since the last meeting of the House of Delegates of the Medical Society of Delaware as shown by the records of the minutes and all the acts of the officers and trustees of the Society in carrying out and promoting the purposes, objects and interests of this Society since the last House of Delegates meeting are approved and ratified and hereby made the acts and deeds of the Medical Society of Delaware.

(The complete report of the Proceedings of the House of Delegates is on file in the Medical Society office and is available to members.)

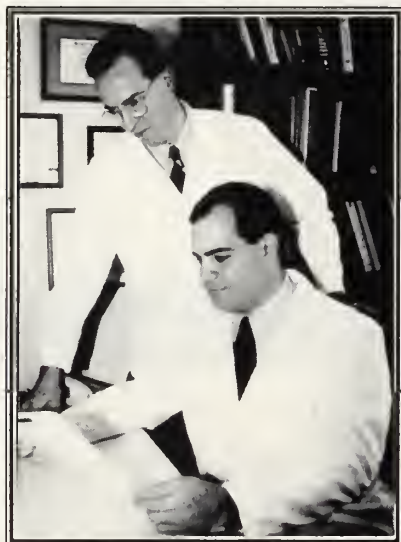
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Absolution Resolution

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My Experience With 33 Patients Infected With HIV

Constantinos G. Hadjipanayis
Carlos R. Plata-Salaman MD DSci

Many of the USA's leading medical schools have developed programs to put medical students in contact with patients as early as their first year. In my first year at Jefferson Medical College, as part of a joint program with University of Delaware and the Medical Center of Delaware, I was afforded an opportunity to work for a short period in the Infectious Disease Clinic at the Wilmington Hospital. It provides ambulatory care for approximately 700 patients with initial or intermediate stage HIV infection. I was able to participate in the care of, and study in depth, 33 of those patients. I should like to recount my experience with those 33 patients, even though this is not a representative sample of the whole. Still, these patients represent my total experience and indeed may be more cases than many physicians have seen in the past 10 to 15 years.

I have tabulated the information I obtained on these patients under four categories: first, history (Table 1); second, symptoms (Table 2); third, secondary infections (Table 3); and fourth, treatment (Table 4). I should like to comment and highlight some of these parameters which I found particularly interesting, and also make a few remarks about the whole experience.

From this experience I might conclude that HIV infection is largely a problem of

Constantinos G. Hadjipanayis is a medical student at Jefferson Medical College of Thomas Jefferson University. Carlos R. Plata-Salaman is a biomedical researcher in neuroscience at the School of Life and Health Sciences, University of Delaware.

VARIABLE	ALL PATIENTS (N=33)	MALE	FEMALE
<i>percentage of patients</i>			
Age			
≤29 yr	6	6	0
30-44 yr	91	52	39
45-59 yr	3	0	3
≥60 yr	0	0	0
Sex			
Male	58		
Female	42		
Race or ethnic group			
Black	73	39	33
White	21	12	9
Hispanic	6	6	0
Residency			
Wilmington	85	48	36
Socioeconomic status			
Poor	85	45	39
Education			
≤12th grade	82	45	36
Current cigarette smoker	64	33	30
History of alcohol abuse	39	24	15
History of injection drug use	70	33	36
History of cocaine use	70	33	36
History of heroine use	21	9	12

*Because of rounding, the percentages may not total 100.

Table 1. Characteristics of HIV patients at the HIV Wellness and the Infectious Disease clinics in Wilmington, Delaware (continued on page 144).

lower socio-economic groups, low educational achievement and (consistent with these) a disproportionately high prevalence in the Afro-American community (Table 1). While this may be true, I really don't know how many HIV patients are under the care of pri-

VARIABLE	ALL PATIENTS (N=33)	MALE	FEMALE
<i>percentage of patients</i>			
Sexual orientation			
Heterosexual	79	39	39
Homosexual	21	18	3
More than 10 sexual partners in past 10 yr	70	45	24
Hemophilia/coagulation disorder	0	0	0
History of blood transfusion	15	0	15
Diagnosis date ≥ 3 yr	48	24	24
CD4 count			
≤ 500	64	45	18
≤ 200	36	27	9
PPD reactivity	18	12	6
History of previous infections			
Syphilis	27	15	12
Other sexually transmitted diseases	45	21	24
Hepatitis	39	18	21
Tuberculosis	6	6	0

Table 1. Characteristics of HIV Patients at the HIV Wellness and the Infectious Disease clinics in Wilmington, Delaware.

vate (non-clinic) physicians. Also, since the disease uses up one's resources rather rapidly and people in this age group don't actually have many financial resources, if one isn't poor to begin with, he/she will soon become poor. Nevertheless, it seems fair to guess that these three characteristics (poverty, race, poor education) define a high risk population.

The great preponderance in the 30 to 44 year age group (over 90 percent) indicates the relatively recent emergence of the disease and its universal fatality. The small number under 29 years of age could be interpreted as an indicator of some success in educational programs in our high schools. If so, this would be one of the few rays of sunshine in a rather gloomy situation. We note in these 33 patients that about half had recognizable disease over three years (Table 2), which may suggest exposure 5 to 10 years ago.

The lifestyle figures, with only 21 percent homosexual but I.V. drug use in 70 percent,

CLINICAL MANIFESTATION	ALL PATIENTS (N=33)	MALE	FEMALE
<i>percentage of patients</i>			
Malaise	33	27	6
Nausea	18	15	3
Vomiting	12	9	3
Diarrhea	30	21	9
Abdominal pain	27	21	6
Anorexia	45	30	15
Weight loss	39	30	9
Headache	27	12	15
Arthralgia	12	9	3
Myalgia	12	9	3
Anxiety/irritability/nervousness	18	12	6
Depression	30	21	9
Lethargy	42	30	12
Insomnia	24	12	12
Dementia	0	0	0
Cough	33	15	18
Shortness of breath	24	12	12
Dyspnea	15	6	9
Skin rash	9	3	6
Skin ulceration	6	6	0
Fever	24	12	12
Pharyngitis	6	3	3
Lymphadenopathy	27	18	9

*Because of rounding, the percentages may not total 100

Table 2. Clinical Manifestations Presented by HIV patients at the HIV Wellness and the Infectious Disease clinics in Wilmington, Delaware.*

seem to suggest a change from the original association with male homosexuality. In this group of patients studied, the association seems to be with promiscuity. I find it difficult to reconcile the high I.V. drug use, the sexual promiscuity, and the STD history with low (39 percent) rate of hepatitis. The history of tuberculosis in 6 percent of patients is ominous indeed, given the emergence of resistant strains.

I found the symptomatology highly interesting and instructive (Table 2), in that in this standardized illness there was no single

symptom or finding that was universal and diagnostic. Even anorexia, lethargy and weight loss — though common were not present in all patients. Cough and malaise were also fairly common, but in this fairly young group with what is considered a universally fatal disease, only 30 percent admitted to being depressed. It must indicate either the indomitability of the human spirit or the power of denial. Nonetheless, the lesson I learned is that diseases manifest themselves differently in people. The host is a very important part of the disease/host relationship.

In terms of secondary infections (Table 3), these are very often the things that bring the illness to our attention and lead to the diagnosis. Striking and unexplained in my mind is the relatively high rate of complications in the men as compared to the low rate in the women. The outstanding one of course is pneumocystis carinii, which was fairly common in the men but nonexistent in this group of women. A larger sample might have shown different results.

In terms of the effect of this experience on me, it has been an exciting experience, enabling me to look ahead and get a foretaste of what it will be like to be a physician. You can't be like a child, worried about "catching" a bad disease. You can't waste time in blame or judgement or recrimination. You must deal with things as they are and try to correct what you can. It was a maturing experience, and I am grateful to the Medical Scholars' Program of the University of Delaware and Jefferson Medical College for making it possible.

Acknowledgements

We thank Robert Burday MD, Dean Winslow MD, Chris Demos MD, and Paul Durbin PhD, for their cooperation in the fulfillment of this study. Research was supported by a grant from the Medical Scholars' Program of the University of Delaware and Jefferson Medical College.

SECONDARY INFECTION	ALL PATIENTS (N=33)	MALE	FEMALE
<i>percentage of patients</i>			
<i>Pneumocystis carinii</i> pneumonia	21	21	0
Toxoplasmosis	6	6	0
Candidiasis	36	30	6
Thrush	30	24	6
Esophagitis	6	6	0
<i>Mycobacterium avium</i> intracellulare	15	12	3
<i>Herpes simplex</i>	15	12	3
<i>Herpes zoster</i>	3	3	0
<i>Cytomegalovirus</i> Retinitis	12	12	0
<i>Streptococcus pneumoniae</i>	3	0	3

*Because of rounding, percentages may not total 100

Table 3. Diagnosed secondary infections of HIV patients at the HIV Wellness and the Infectious Disease clinics in Wilmington, Delaware.*

TREATMENT	ALL PATIENTS (N=33)	MALE	FEMALE
<i>percentage of patients</i>			
Zidovudine (AZT)	30	21	9
Didanosine	0	0	0
Zalcitabine	3	0	3
Trimethoprim with sulfamethoxazole	30	21	9
Isoniazid	15	9	6

*Because of rounding, the percentages may not total 100.

Table 4. Current treatments of HIV patients at the HIV Wellness and the Infectious Disease clinics in Wilmington, Delaware.*

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Radiology at the Centennial: Roentgen's Ray Proves Durable

James F. Lally MD

At a small college in Hanover, New Hampshire, in the middle of the winter of 1896, an astronomy professor, Edwin Frost, decided to repeat the recently reported experiments of a German physics professor. A boy from the local town of Hanover, a patient of Frost's physician-brother, was the subject of the landmark achievement. The lad had fallen and injured his wrist while skating on the Connecticut river several weeks prior to the much-heralded experiment. After a 20-minute "exposure" of the boy's wrist under a Crookes tube, the developed photographic plate showed the expected fracture of the wrist. Thus, the bucolic surroundings of Dartmouth College became the unlikely setting for the beginning of the American experience with Professor Roentgen's magical, invisible rays.

Fast forward through many decades to another laboratory in England in the early 1970s. Godfrey Hounsfield, a scientist working for EMI Ltd., a company primarily known as the producer and distributor of the Beatles' records, is trying to solve a riddle. Hounsfield was struggling with the puzzle of how to mathematically reconstruct an image from an infinite set of its projections or from viewing it at numerous angles. He was aware of the early work of the Austrian mathematician, J. Radon, who, in 1917, proved that a two-dimensional or three-dimensional object could be reconstructed using mathematical techniques.

As in much of science, innovators build on the ideas of others. The American physicist, Allen Cormack, in a prescient paper in the *Journal of Applied Physics* in 1963 theorized that the mathematical analysis of x-ray profiles could be used to reconstruct images.

Hounsfield made use of this groundbreaking theorem, and the ideas of others, when he constructed the first computerized transverse axial scanner. The original EMI scanner required 20 minutes to generate one axial slice. For this one slice, the computer had to solve the equivalent of 28,000 simultaneous equations.

Computed tomography was first described in the United States by G. Hounsfield and Dr. James Bull at Dr. M. Schechter's spring neuroradiology conference in New York in May 1972. The first U.S. scanners were acquired by the Mayo Clinic and the Massachusetts General Hospital in the summer of 1973.

These two stories are major stops on what the writer E. Grigg has called "the trail of the invisible light." That "trail" has lead inexorably from the laboratories of Roentgen and Hounsfield and the grassy quadrangle at Dartmouth to the pinnacles of achievement of 20th century science. For his work in defining a new beam of energy, "Eine Neue Arte von Strahlen," Roentgen was awarded the first Nobel Prize in physics in 1901. For their work on the theory and development of computed tomography, Allen Cormack and Godfrey Hounsfield shared the Nobel Prize in medicine in 1980.

Other forms of energy, such as sound waves and the resonant signal from spinning protons, have been used to provide even clearer and often more diagnostically important information, but they have not surpassed the x-ray in its worldwide utility and applicability nor have they had its durability.

A technology such as the x-ray that is simple, elegant and, like the potter's clay, capable of being molded and married to newer

technologies, high-speed computers are the best example, will reinvent itself as new technologies emerge. Although radiology has this prowess for constant technological rejuvenation, it will survive as an integral part of medicine only when it stays focused on its primary function to act as an extension of the

senses, a tool for diagnosis. While its technological achievements have been dazzling, they must ultimately survive the test of whether they serve the needs of the sick and whether they promote and enhance the commonweal.

Risk Vs. Reward

Stephen L. Hershey MD

The delivery of health care is being debated and charged daily. Physicians especially are being singled out as targets by the reformers because of the perception that we control the flow and direction of the health care dollar. The reality is, however, that the health insurers control the cash flow and have for a long time. The reason they (health insurers) have turned and continue to turn the tables on providers is that they no longer like the terms of the health insurance risk that has always been their responsibility. This has been aided and abetted by the liberal politicians who continue to perpetuate the huge lie that the U.S. spends too much on health care and can no longer afford to do so. We spend much more just servicing our national debt!

Insurance as defined in Webster's Dictionary is a very simple proposition: "the act or business of insuring against loss or harm in consideration of a payment *proportioned* to the *risk* involved." The assumption of risk is clearly the responsibility of the insurer, not the insured or other third party. If in fact the insured were willing to take the risk, he or she would not buy insurance in the first place. Why, therefore, are the physicians so

willing to enter into capitation arrangements? Capitation is shifting the risk to the provider so the insurer has no risk. If one accepts the risk, there should be a commensurate increase in the compensation, but the exact opposite is the case. Not only are physicians accepting all the financial risk, they are doing so for deep discounts. In any insurance contract, the insured pays more if the insurer is taking a higher risk of loss.

Insurers love capitation because they are absolved of any financial risk and take their fee off the top before any treatment is rendered. Physicians are ill equipped to accept these risks. They did not get a medical education to become insurance brokers.

If physicians want to assume financial risk, they need only contract directly with their patients as before third party payors came along. Physicians should be very cautious about entering capitation contracts. Beyond the financial risks, they violate the very core of what being a physician is all about — patient advocacy. Physicians should do the best they can for their patients, not just what they can get away with or worse — deny care!



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Plaintiffs Are Patients Too

John M. Levinson MD

The December 1995 issue of the *Delaware Medical Journal* contains an editorial entitled, "The Need for an Improved Judicial System," by E. Wayne Martz MD. It is a very sound article and merits our careful attention. Dr. Martz stated that he would like to explore many other facets of the medical-legal problems that plague our profession. His article has prompted me to share with you an evolution of thinking, and a way that all of us can reduce this "plague."

Almost 30 years ago I was first asked to defend one of my colleagues who was being sued for malpractice. Over the next decade, physicians and lawyers representing professional liability carriers sought my services. On more than one occasion, I declined to become involved, as I felt that the physician had made fundamental errors that could not be condoned. In one instance, both the physician and the lawyer became hostile when I disagreed with the way the patient, now the plaintiff, had been treated. In cases where I have felt that in clear conscience I would not be able to defend the physician, I have refused to be involved. I also have assured the physician that I would not be available to the plaintiff in cases.

Sporadically in the early years I was also asked by plaintiffs' attorneys to review cases. On several occasions I explained why there was no merit to the allegations and the cases were dismissed. On one occasion, a very able practitioner had made a fundamental error that might have led to a court judgement in six figures. Fortunately, the attorney and the plaintiff were very fine people whose goal was basically to have the physician acknowledge his error. They were not looking for fi-

nancial gain. With this understanding, I was able to help arrange a settlement for \$6000, and that was the end of it.

In another instance, where the attorney anticipated little financial incentive I was able to get the case to arbitration. I did not charge for my services, but gained satisfaction in seeing both the physician and hospital realize how they might have performed better and with greater sensitivity to a desperately ill patient.

In several other instances, I have assisted poor patients represented by attorneys with very limited resources and have not rendered a charge. Over the years, physicians have given care without charge to patients - why not with plaintiffs' care?

I have learned that the better plaintiffs' attorneys refuse fifty percent of the cases brought to them, as they are felt to be questionable or frivolous. The remaining cases are studied further and a medical expert is asked to review the issues involved. Of the several dozens of these I have reviewed in recent years, I have found about half of these either without merit or cases of complications, not malpractice. I am pleased to note that almost all of these were subsequently dropped by the plaintiffs' attorneys! Why was I placed in this position of being both judge and jury? The answer is simple. My opinion has been respected because in those cases that I have felt the plaintiff was wronged, I have defended the wronged patient and have and will continue to go to court in their behalf. My perception about plaintiffs' attorneys in Delaware over the past 30 years is that a profound change has occurred. Today they are generally more able, prepare their cases bet-

ter, and wish to avoid frivolous lawsuits. Increasingly the better and more honorable lawyers in their profession wish to work constructively with Delaware physicians. If all members of both professions could be more professional, many problems might disappear.

Not long ago it was virtually impossible to find a Delaware physician who would be available to a plaintiff in the same way as he or she would be available to his or her professional colleagues. There are still large medical specialties where none of the physicians will get involved. Today, however, I can identify at least 10 of our most highly respected physicians who have crossed the line. They too, have had the experience of helping "weed out the bad cases."

If all Delaware physicians would be available to review all the cases of alleged malpractice I believe the following would occur:

1. The people of our state would have a greater respect for our integrity.
2. The high quality of medicine in Delaware would be further improved.
3. Attorneys would have little reason to bring in out-of-state experts — some of dubious repute.
4. More cases of alleged malpractice would be dismissed as plaintiffs' attorneys gain more respect for our opinions.
5. With fewer accepted for litigation, legal costs would decrease and decreased professional liability rates for physicians would follow.
6. Fewer physicians would be traumatized by being listed in the National Practitioner Data Bank.
7. Lastly, if unbiased review is achieved, it will do more for the medical-legal "plague" than all the various tort reforms and the like we have been busily talking about for over 20 years.

It is not easy to testify against a colleague. But is it fair to deny expertise to the plaintiff? The day is long gone when certain patients were routinely excluded from certain private medical offices in our state. Let us also remember that every plaintiff is also a patient. They are one and the same, and they deserve our best.



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OBITUARY

Elmer R. Gross MD

Eric J. Oliet MD

Elmer R. Gross MD, a longtime Wilmington dermatologist, died of respiratory failure at his home in Jerusalem, Israel, on April 1, 1995. He was 87 years old at the time of his death.

Dr. Gross grew up in the mining town of Glenline, Pennsylvania, located near Wilkes-Barre, where he spent much of his youth helping out in his father's general store. He left home for the University of Michigan, where he earned both his undergraduate and medical degrees. Following his medical school graduation in 1933, Dr. Gross returned east and spent a year doing a rotating internship at the Delaware Hospital in Wilmington. Between 1934 and 1937, Dr. Gross completed his graduate studies and dermatologic preceptorship at Columbia University.

In 1938, Dr. Gross joined the dermatology practice of Dr. Joseph V. Klauder in Philadelphia. The two men were in practice together until about 1942, when Dr. Gross joined the Philadelphia dermatology practice of Dr. Carroll S. Wright. Both Drs. Klauder and Wright had studied under the eminent dermatologist Jay F. Schamberg MD, and both were prominent figures in Philadelphia dermatology at that time.

Dr. Gross held a variety of academic positions in Philadelphia. He served as an Associate Clinical Professor of Dermatology and was Chief of the Syphilis Clinic at Temple University School of Medicine. He was also on the staffs of Wills Eye Hospital, Philadelphia General Hospital and the Graduate School of the University of Pennsylvania. During all the years that Dr. Gross practiced dermatology in Philadelphia, he resided in Wilmington and commuted to Philadelphia daily.

In about 1949, in addition to his practice in Philadelphia, Dr. Gross started a part-time dermatologic practice in Wilmington. This was located in a small private hospital on West Street in downtown Wilmington. What was fairly unique about this hospital was that it was primarily staffed by only Dr.

Elmer Gross and his two physician brothers. Dr. Gross continued spending his mornings working in Philadelphia and his afternoons and evenings practicing dermatology in Wilmington until the mid 1950s. At that time he experienced what was thought to be a minor myocardial infarction, and it was at that point that he decided that he was weary of the daily commute to Philadelphia. Dr. Gross terminated his Philadelphia practice and practiced dermatology full-time in the downtown Wilmington area until 1986. In Delaware, Dr. Gross was on the clinical staffs of the Delaware Hospital, Memorial Hospital, Wilmington General Hospital and St. Francis Hospital.

Over the years, Dr. Gross published a variety of scientific papers which included such diverse topics as: A Survey of Syphilitic Optic Atrophy (1936); Prevention of Industrial Dermatitis (1940); Solid Carbon Dioxide in the Treatment of Acne Scars (1949); The Care of Dentists' Hands (1950); Use of Ethyl Chloride in Minor Dermatologic Surgery (1951); Skin Planing of Cosmetic Defects (1956); and Causes and Treatment of Hair Loss (1964). Some of Dr. Gross' publications were presented internationally. In fact, in his office Dr. Gross displayed a world map in which he placed pins to mark all of the international locales where he had presented scientific papers.

One of Dr. Gross' most serious professional misgivings was his failure to publish a study he performed in 1945 regarding the use of long-acting penicillins in the treatment of syphilis. He had written a publication which included several case studies demonstrating the efficacy of a penicillin-beeswax-peanut oil preparation for the treatment of syphilis in the ambulatory patient as an office procedure. His senior associate at the time discouraged Dr. Gross from submitting the article for publication because its findings were considered too radical for the times.

Throughout his life Dr. Gross freely gave of his time and resources to many civic and

charitable organizations. He chaired both the medical division of the Jewish Federation of Delaware and the Jewish National Fund for the state of Delaware. He was a founder of the Albert Einstein Academy, and he was an avid supporter of his alma mater, the University of Michigan.

From my years of association with Dr. Gross, I believe that what his patients will best remember him for was his warm and encouraging manner. He had a way of putting his patients at ease that I believe helped to hasten their response to his therapy. Although Dr. Gross last practiced medicine almost 10 years ago, many of his former patients continue to reminisce about his kindness and compassion.

Equally important, Dr. Gross will be remembered by all who knew him as a loving and dedicated father and husband. Almost all of his non-dermatologic activities centered around his wife, children and grandchildren. Dr. Gross is survived by his wife, Sarita, of Israel; two sons, Michael of Birmingham, Alabama, and Leslie, of Wilmington; a daughter, Drora Charap, of Charleston, South Carolina; and eight grandchildren.

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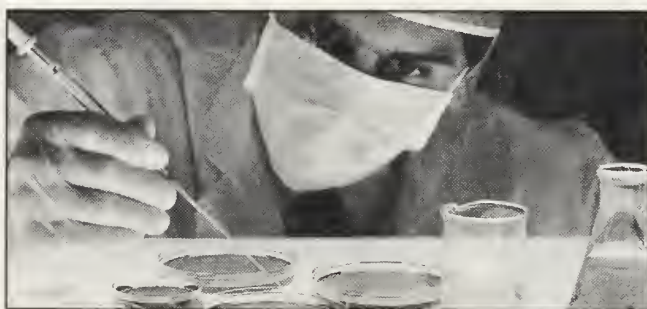
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BOOK REVIEWS

Doctor, What Should I Eat? Nutrition Prescriptions for Ailments in Which Diet Can Really Make a Difference, by Isadore Rosenfeld MD, Random House, New York 1995, 425 pp., \$25.

Dr. Rosenfeld, a full time practicing internist-cardiologist, is the Rossi Distinguished Clinical Professor of Medicine at Cornell University Medical College. This book is a practical manual for patients to decide what food changes can help them get from specific illnesses to health. The author says that most doctors do not pay much attention to nutrition, because they have little knowledge of it, and are uncomfortable with it. Until recently most medical schools taught nothing of nutrition, and even now, he says, only 25 percent of medical schools have required courses in nutrition.

Dr. Rosenfeld explains in his foreword: "This book spells out specifically what you should and should not eat for more than seventy common disorders in which nutrition can make a difference. In each one, I have explained the nature of the disease, how it develops, as well as how and why the food you consume can affect the outcome."

Some of the diet recommendations are based on scientific evidence, whereas others are based on culturally accepted folklore. In every instance, the author makes clear which is which. He gives the scientific evidence when available, but also endorses the folklore sponsored food prescriptions, with the advice that since it works for others, it may well work for the reader. In this category fall the

prescriptions of cranberry juice for urinary tract infections and chocolate for premenstrual syndrome.

This book, although long, is written in an informal style and is very readable. It has numerous tables of contents of foods, and many many specific dietary prescriptions for specific illnesses. The index is thorough and helpful. In these days of holistic medicine, this book will be a valuable referral for the busy clinician.

David Platt MD

Making the Patient Your Partner, Communication Skills for Doctors and Other Caregivers, By Thomas Gordon PhD and W. Sterling Edwards MD, Auburn House, Westport CT, 211 pp.

Dr. Gordon is a PhD psychologist who has pioneered effectiveness programs for industrial managers. His methods and his books are now used in thirty seven countries. In this book he has teamed up with Dr. Edwards, who is retired Emeritus Chariman of Department of Surgery of University of New Mexico School of Medicine. Together they have produced a volume which is a how-to manual to provide effective and compassionate care to patients with progressive or life threatening illnesses.

The authors say they wrote this book specifically for all health care professionals who relate directly to patients, and for all others, including family, who care for the ill. They believe it is possible for caregivers to help the sick person to feel respected, trusted, and

supported at every stage of the illness. They go on, "It is possible for caregivers, both professional and non-professional, to learn how to help the sick find peace, hope and meaning in life regardless of the course of the physical part of the illness — to help empower patients to deal more constructively with their pain, their loneliness, their fears, and hopes."

The key to their method is active listening. They document and illustrate this by many case histories and patient vignettes. Some of the chapter titles are, "Emphatic Listening, Dealing Effectively with Conflicts, Helping Patients Maintain Hope, Helping Patients Cope With an Adverse Diagnosis, Helping Patients Maintain Hope, Helping Patients Find Meaning."

Besides an extensive bibliography, the authors supply a list of recommended books on the subject by others, and names and addresses of medical organizations which serve as sources of information for communication skills training for health professionals. This book will be an excellent addition to the reference library of any physician who cares for terminally ill patients.

David Platt MD

A New Mind-Set for a New Era, A Physician's Commentary on the Health Care Crisis and Society, By Malcolm S.M. Watts MD, Vantage Press, NY, NY, 1995, 105 pp., \$12.95.

Dr. Watts is an internist, a medical editor, and a prize winning medical writer. When I started to read his little book, I thought I was going to find another detailed plan on how to reform health care. Instead, the whole book is a philosophical discussion of the author's view of what historically has been wrong with health care, how it got that way, what our true goals should be, and how all of us need "a new mind set," as the title says, to understand the required goals for a health care system.

He writes of the upheavals in medicine since the advent of Medicare and Medicaid in 1965, of the good those programs do, but of their inadequacy in leaving huge numbers of uninsured and underinsured, of the problems

of AIDS, of violence, of smoking, of alcoholism and auto deaths, of guns, of unhealthy lifestyles, of the dangers of the population explosion worldwide, of the shortage of medical generalists and the surplus of specialists and subspecialists, and of the soaring of practice costs to keep up with the flood of paperwork demanded by third parties. He accepts the definition of the World Health Organization that "Health is a state of complete physical, mental, and social well being, and not merely the absence of disease and infirmity."

Dr. Watts concludes that the present health care crisis is a part of the overall societal problem and that a new mind set with new value judgements is needed to put less emphasis on treating diseases and more on improving the health and well-being of humans and of our planet, with less competition and confrontation and more coordination and cooperation.

This is a tall order.

David Platt MD

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MSD MONTHLY ACTIVITIES

Working for You: December 1995

Leadership Activities

- Mary LaJudice and Mark Meister met with MBNA representatives to discuss MSD Gold Card program
- Mr. Meister met with Claymont Community Center administrator to discuss proposal for continued funding of the Claymont Health Service.
- Doctors Carol A. Tavani, Michael J. Bradley, Anthony Ciarlo, Stephen Grubbs, James Marvel, Stephen Permut, Resident Section Representative Timothy Wong and Mr. Meister represented MSD at the 1995 Interim AMA House of Delegates meeting in Washington, D.C.
- Dr. William Duncan and Beverly Dieffenbach represented MSD at a meeting of the Delaware Health Care Commission's Cost Containment Committee.
- Mr. Meister and Jana Siwek met with representatives from the HCFA Region III office to discuss Medicare plans for implementing its "correct coding" initiative and revamping of Medicare's claims processing systems nation-wide. A separate meeting with the Xact Medicare V.P. for Provider Services was also held regarding these topics.
- Mark A. Meister attended a meeting of the DHCC Health Data Committee.
- Mr. Meister represented MSD at a meeting of the Delaware Public Policy Institute Welfare Reform Task Force.
- Mr. Meister attended a seminar sponsored by Saul, Ewing, Remric & Saul regarding global risk contracts for physicians.
- Meetings were held with members of the Delaware Delaware Assembly to discuss the Society's legislative agenda for 1996.
- Michael J. Bradley DO represented the Society at a meeting of the DHCC Primary Care Committee
- Dr. Leo Raisis, Phil Corrozi and Mr. Meister met with representatives of the Delaware Department of Labor and the Industrial Accident Board to discuss the department's proposed bill to establish a fee schedule for

workers compensation. (The proposal has been withdrawn)

Physicians' Advocate Program Activities

- Worked with representatives from carriers and the state regarding implementation of Diamond State Health Plan. Compiled a physician's office guide to Medicaid/Managed Care.
- Mailed legal contract reviews for Principal Health Care and MetraHealth to physicians participating in the Contract Review Service.
- Consulting for medical practices regarding practice evaluation, practice management issues, and search for new employees.
- Continued work on Centralized Credentialing Verification Service (CCVS). Presented business plan to round table carrier group. Aided in employment search for administrator for CCVS.
- Finalized plans for 1996 workshop series. Began developing brochure to be mailed early 1996. In response to requests, two additional workshops will be offered in conjunction with MGMA including: ICD-9-CM and CPT Coding.
- Answered various inquiries from physicians and staff regarding Medicaid/Managed Care, work comp, collection letters and guidelines for closing a practice.

Continuing Medical Education Activities

- Sponsored 20 educational activities for Category 1 credit.

Major Meetings

- DHCC Certificate of Need
- Environmental and Public Health Committee Meeting
- Managed Care Round Table Meeting
- DHCC Health Data Committee Meeting
- DPPI Task Force Meeting
- Global Risk Contract Meeting
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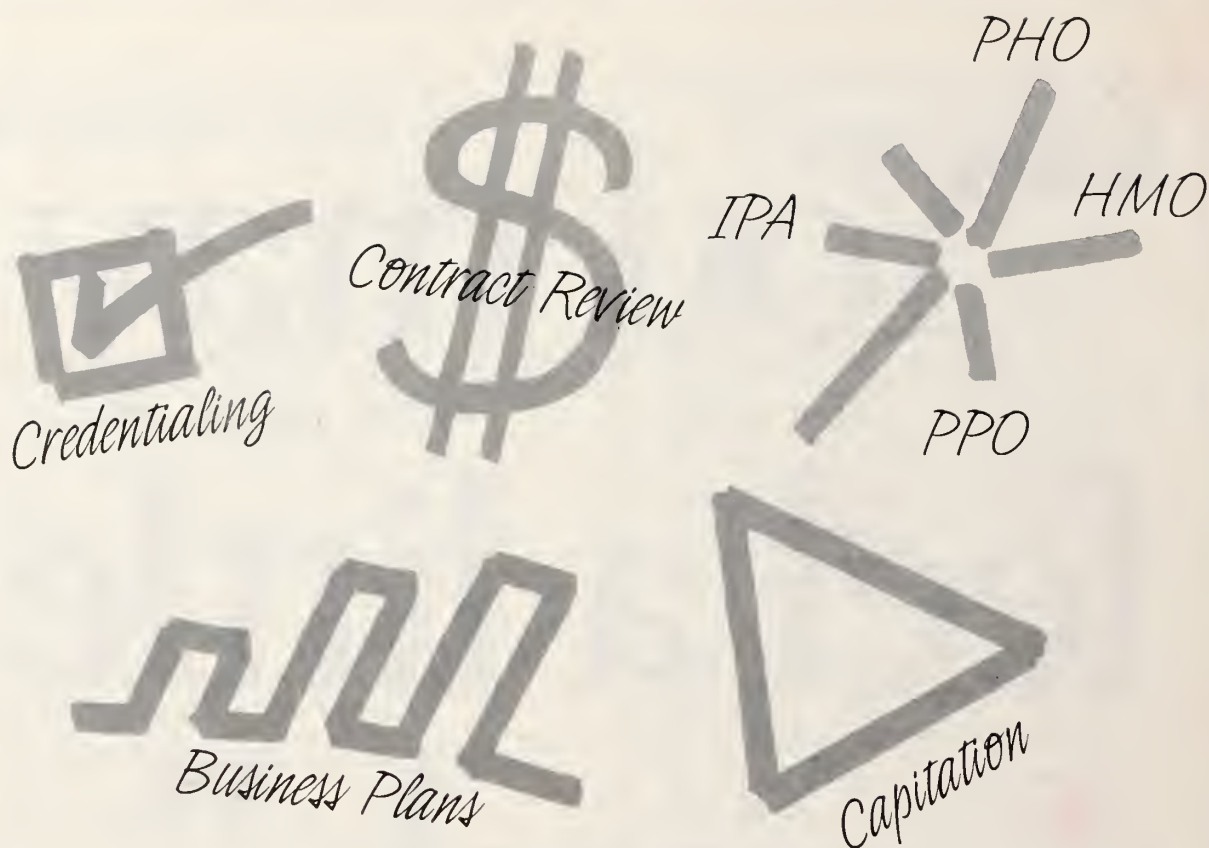
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VOLUME 68

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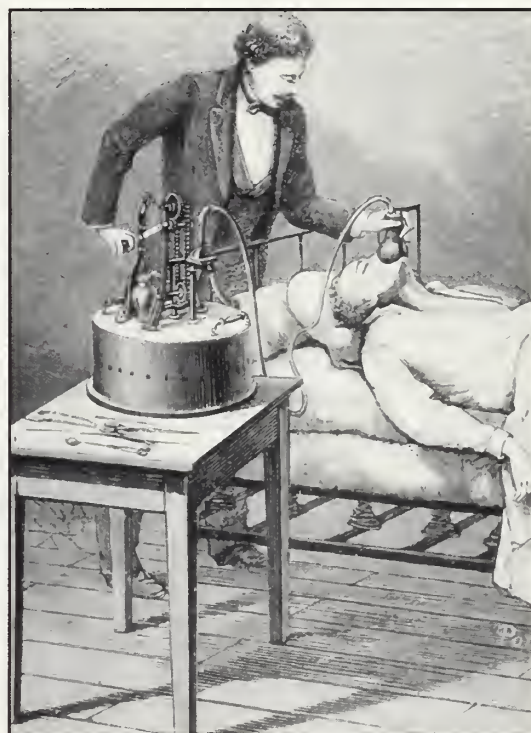
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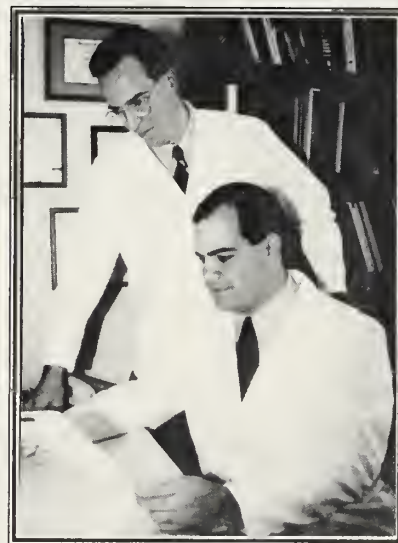
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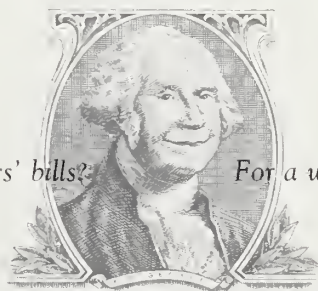


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port the popular *Physicians' Advocate* workshops and other Society activities.

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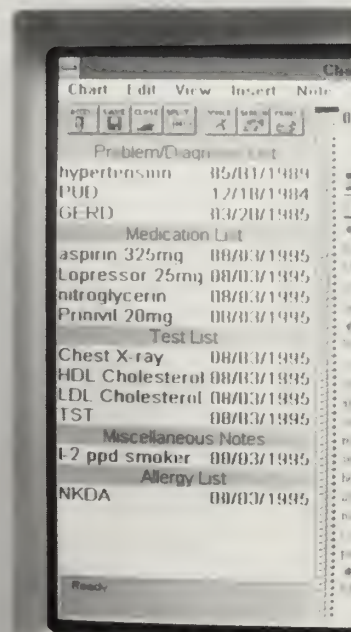


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Special Issue:
Low Back Pain

Introduction

Because of the long history of tensions and ill-will between physicians and chiropractors, when I received a manuscript last year from a Doctor of Chiropractic, I treated it gingerly. I was aware that the AMA had lost a long standing suit over discrimination against chiropractors. I was also aware that they seem to play an increasing role with athletic teams and sports medicine. I recognized that hundreds of thousands if not millions of people seek their help, and that their services may be reimbursed under a number of health insurance programs. Very often this is conditional on a primary care physician as gatekeeper. This has created a problem for many of our members in that they know little or nothing about chiropractic or the indications for its use. They need to learn something about it if they are to deal with the problem intelligently.

The chiropractic author and I discussed these matters at some length, and we agreed on some modifications to meet our standards for publication. I sought the approval of the MSD Board of Trustees, and they voiced no objection to its publication. I raised the question at a meeting of our Editorial Board. They did not want to appear to be promoting chiropractic, and suggested that it be published with physician authored articles on the management of back sprain/strain/pain in the same issue. That sounded reasonable and a good approach, but then I found that most orthopedic articles deal with this as a subset of lumbar disc problems. That's not what the chiropractors were talking about at all. I finally found three suitable articles on the subject of back sprain (by whatever name) in leading scientific journals, and each journal has granted us permission to reprint them if we give appropriate credit.

Thus the scientific portion of this issue of the *Delaware Medical Journal* consists of one article "The Outcomes and Costs of Care for Acute Low Back Pain Among Patients Seen by Primary Care Practitioners, Chiropractors, and Orthopedic Surgeons," reprinted with permission from *The New England Journal of Medicine*, 333:14,913-917; and another article "Family Physicians, Chiropractors, and Back Pain," from *The Journal of Family Practice* 35:5,551-555, 1992, reprinted permission of Appleton & Lange, Inc.; and a new original article by Leonard Vernon DC, a local chiropractor setting forth his approach to the treatment of low back pain/strain/sprain. I hope this will lead to a better understanding all the way around.

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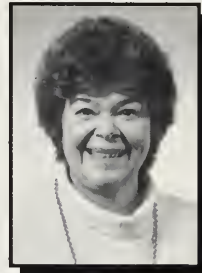
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Spinal Manipulation as a Valid Treatment for Low Back Pain

Leonard F. Vernon DC

Abstract

The practice of chiropractic has been regulated in the State of Delaware since 1937.¹ Since that time, the battle lines in the state between medicine and chiropractic have been drawn. This war has existed on both the political and clinical fronts, and although it has always been believed by the chiropractic profession that once the "scientific evidence" of the benefit of chiropractic was proven, the war would end. This has not occurred to the extent believed. Even with its 1980 victory over the AMA,² chiropractic has still been unable to achieve full acceptance as a clinical discipline among other professions. Many hospitals in this country have opened their doors to DCs. This by and large, has solely been for economic reasons and not as a recognition of the clinical benefit of manipulation.

There is, however, a growing population of primary care physicians and researchers suggesting the benefit of manipulation for low back pain as well as suggesting that increased cooperation between MDs and DCs could be of extreme benefit to the patient population at large.³⁻⁶ This group continues to be in the minority. However, with increased knowledge of the benefits of spinal manipulation and the scientific evidence that now exists to support its efficacy, it is now believed that this interprofessional referral pattern

will increase. In addition, many managed care programs now require primary care physicians to determine the necessity for referral to a chiropractor, thus causing a need for the primary physician to have some knowledge of spinal manipulation. This paper is presented to inform the physician community of Delaware of some of the evidence pointing to the efficacy of spinal manipulation as a treatment for low back pain.

Overview

Spinal manipulation as a healing art has been practiced for centuries. Over the last 40 to 50 years, this treatment modality has increasingly been associated with chiropractic.⁷ This is mainly because of its all but total abandonment by osteopathy.

In the last five years, independent medical research with outcomes favorable to the chiropractic treatment of patients with low back pain has stimulated a reappraisal of the role of spinal manipulation. The two most recent outcome studies, with the most credibility to date, have been, 1) the study performed by the RAND Corporation,⁷ which specifically examines spinal manipulation for low back pain (its results affirm that spinal manipulation is an effective modality when treating low back pain patients) and 2) the report by the Agency for Health Care Policy and Research (AHCPR). This study, performed under the auspices of the U.S. Dept. of Health and Human Services, found that spinal manipulation was a valid tool for the treatment of low back pain. Specifically, the panel's

Leonard F. Vernon DC is an Assistant Professor of Clinical Sciences at University of Bridgeport, College of Chiropractic and has practiced chiropractic in Delaware for 17 years.

findings and recommendations were as follows: "Manipulation can be helpful for patients with acute low back problems without radiculopathy when used within the first month of symptoms." Their summary of findings was, "the evidence for effectiveness of manipulation varies depending on the duration of the patients' presenting symptoms. For patients with acute low back pain symptoms without radiculopathy, the scientific evidence suggests spinal manipulation is effective in reducing pain and perhaps speeding recovery within the first month of symptoms."⁸

Spinal manipulation can be broadly defined into two categories:

1. Nonspecific long lever manipulation
2. Short lever high-velocity spinal adjustment.

Long lever manipulations use the femur, shoulder, head or pelvis to manipulate the spine in a nonspecific manner. Short lever spinal adjustments use specific contact points on the vertebrae to affect a specific vertebral joint. It is this method which is most closely identified with chiropractic practice. It should be recognized that many chiropractors use both methods in their day-to-day practice.

Over the years, the medical literature has been replete with papers touting the dangers of manipulation. This has mainly centered on the cervical spine region where it is believed that rotary manipulation techniques in certain individuals could induce cerebral vascular accidents.⁹⁻¹² When first published, the chiropractic profession was in an uproar, believing it had once again been unfairly picked on by organized medicine, believing that the findings were politically motivated and rarely of clinical significance. In reality, it was probably a combination of both. In the last five years, the chiropractic literature has published a number of papers dealing with the apparent danger of rotary manipulation in certain members of the population.¹³⁻²⁰ This danger has also been publicized by various newsletters published by chiropractic malpractice carriers. Recognition of this potential danger and the acceptance of this potential danger by the profession was a giant step and

was necessary for the profession to enter the scientific community.

The published literature reveals little of the side effects of spinal manipulation in the treatment of low back pain.³ Although it does exist, an examination of the literature suggests that in all probability a misdiagnosis of an underlying pathology was made by the DC and the patient was not treated properly,⁷ a problem that is not unique to chiropractic as misdiagnoses occur within all professions. Shekelle and Associates estimated the rate of occurrence of cauda equina syndrome as a complication of lumbar manipulation to be on the order of less than one case per 100 million manipulations.⁷ Curtis and Bove state that the chances of a serious incident occurring as a result of cervical manipulation to be 1:400,000 to 1:1,000,000 procedures.³ As always, treatment must be assessed by the degree of benefit versus the risk associated with such a procedure. Because no survival benefit has ever been shown or claimed, the assessment is presently based on relief of the pain, time to relief of pain, improvement in functional status, and days lost from work. Clinical evaluations such as range of motion, flexibility and other physiologic variables could be used, but these correlate poorly.²¹

How Does Manipulation Work?³

Manipulation therapy is the art of restoring a full and pain-free range of motion to the joints. The theoretical basis for manipulation is that hyper- or hypomobile joints produce local and distant effects as the result of abnormal afferent and efferent nerve irritation from the joints, synovial membrane, and other soft tissues. Manipulative therapy is not as easy as it looks. It is a skill that is attained after years of experience. The sensitivity of the hands to appreciate tissue compliance as well as subtle joint movements takes time to develop. Manipulation is generally performed by taking joints to their end point of motion (long lever technique) and then isolating the joint to be manipulated by local pressure on prominence of the articulating bones within the stretched area (short lever). Once isolated, a high-velocity, but low-amplitude thrust, is delivered to the joint and an

audible release usually signifies that the manipulation has been successful. When done properly, the procedure is usually painless and the joint is moved past its passive range of motion, but not outside its anatomical integrity. There is, however, lack of agreement among non-DC clinicians that this joint fixation is a clinically definable entity. However, many DCs with clinical experience believe that patients with evidence of joint fixation and a recent episode of back pain are at a higher risk for relapse than those who do not evidence joint fixation. It is for this reason that many DCs believe that patients should undergo manipulations to relieve the undesirable joint restriction, believing that this will give a more lasting improvement in symptoms.^{7,22} This theory has not been subjected to extensive scientific study and needs further investigation. The scientific literature does not deal with the extensive physiological and biomechanical changes that take place during manipulation.²³

Frequency of Visits

A frequently asked question deals with the frequency of visits needed to relieve pain and symptoms. One study showed the average number of visits was 17.4 visits for treatment of back pain by the DC, while the general physician showed as 7.7 visits.²⁴ However, from a monetary standpoint another study, although suggesting increased frequency of treatment over the MD physician practitioner, indicated that chiropractic care was less costly than medical care when certain ICD-9 diagnosis codes were examined.²⁵ Other studies have also shown that in patients who were treated with sham manipulation versus true manipulation, those treated with true manipulation showed significantly more clinical improvement.²⁶ Nwuga found manipulation to be superior to conventional methods in the treatment of the low back pain patient with a specific symptom complex.²⁷ Other studies were more cautious with their results, yet all believe their findings warranted additional investigation into the benefits of spinal manipulation.²⁸⁻³³

Back pain is the second leading reason reported by patients for visiting physicians.

Approximately 13 million annual visits are made to physicians for chronic low back pain.³ This translates into an estimated \$5 billion spent in the United States on the diagnosis and treatment of back pain. It is estimated to be the second leading cause of work days lost. In the medical setting, family physicians saw 38.6 percent of patients with acute and chronic back pain compared with 36.9 percent seen by orthopedists, 16.9 percent by osteopaths and 7.6 percent by internists. Back symptoms are estimated to be the third most common reason for visiting a family physician. Chiropractors account for about twice the number of visits for back pain as physicians. Thus, for musculoskeletal problems, family physicians and chiropractors provide the majority of ambulatory care in the health care system.³ Although they seem to serve similar populations, their services do not tend to be competitive in nature. It appears to be an unfamiliarity with what chiropractors do that inhibits the referral of low back pain patients to chiropractors for care. One study showed that 50 percent of family physicians surveyed believed they were only slightly or not informed at all about the clinical scope and skills of chiropractors, although 26 percent saw them as an excellent source of care for certain musculoskeletal problems, with only 3 percent seeing chiropractors as "quacks."³

It is my hope with the reading of this paper that physicians will be encouraged to search out the literature and they will find not only has this once "unscientific cult" made great strides in advancing the scientific evidence that spinal manipulation has scientific merit, but that the medical community as well has begun to recognize this. Family physicians who choose to refer their back pain patients to a chiropractor for spinal manipulation do not need to embrace the chiropractic belief system, rather they need only accept that spinal manipulation is one of the few conservative treatments for low back pain that have been found to be effective in randomized clinical trials, and the risk of complications from manipulation is low.

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The Outcomes and Costs of Care for Acute Low Back Pain Among Patients Seen by Primary Care Practitioners, Chiropractors, and Orthopedic Surgeons

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North Carolina Back Pain Project*

Abstract

Background

Patients with back pain receive quite different care from different types of health care practitioners. We performed a prospective observational study to determine whether the outcomes of and charges for care differ among primary care practitioners, chiropractors, and orthopedic surgeons.

Methods

Two hundred eight practitioners in North Carolina were randomly selected from six strata: urban primary care physician (n=39), rural primary care physicians (n=48), urban chiropractors (n=32), rural chiropractors (n=32), orthopedic surgeons (n=29), and primary care providers at a group-model health maintenance organization (HMO) (n=28). The practitioners enrolled consecutive patients with acute low back pain. The patients were contacted by telephone periodically for up to 24 weeks to assess functional status, work status, use of health care services, and satisfaction with the care received.

Results

The status at six months was ascertained for 1555 of the 1633 patients enrolled in the study (95 percent). The times to functional

recovery, return to work, and complete recovery from low back pain were similar among patients seen by all six groups of practitioners, but there were marked differences in the use of health care services. The mean total estimated outpatient charges were highest for the patients seen by orthopedic surgeons and chiropractors and were lowest for the patients seen by HMO and primary care providers. Satisfaction was greatest among the patients who went to the chiropractors.

Conclusions

Among patients with acute low back pain, the outcomes are similar whether they receive care from primary care practitioners, chiropractors, or orthopedic surgeons. Primary care practitioners provide the least expensive care for acute low back pain. (*N Engl J Med* 1995;333:913-7.)

Disabling back pain is common.^{1,2} Back pain is one of the most frequent reasons that patients visit primary care physicians and is the second most common reason for time taken off from work.^{3,4} In the United States, estimates of direct medical costs attributable to back pain are as high as \$25 billion annually.⁵ Patients with acute low back pain can choose among several types of health care providers. They may initially visit primary care practitioners, chiropractors, or specialists such as orthopedic surgeons. Care from

*Reprinted with permission from the *New England Journal of Medicine*, Vol 333, No.14, 913-917.

doctors of chiropractic emphasizes spinal manipulation, which has been shown to be effective in several randomized trials.⁶

We performed a study to determine the outcomes among patients with acute low back pain seeking care from a variety of practitioners. Specifically, we wanted to determine whether outcomes and charges vary according to the type of provider initially seen for an episode of acute low back pain.

Methods

The setting for our study was North Carolina, whose population is almost equally divided between urban and rural residents. Twenty-two percent of the population is black.⁷ Almost 600 chiropractors practice in North Carolina, and previous research by our group has demonstrated that 39 percent of persons seeking care for acute back pain go to a chiropractor first.⁸

Practitioners

Using medical and chiropractic state-licensure files, we randomly selected practitioners from six strata: urban primary care physicians, rural primary care physicians, urban chiropractors, rural chiropractors, orthopedic and neurologic surgeons, and primary care physicians and a small number of nurse practitioners and physician's assistants at a group-model health maintenance organization (HMO). We defined primary care as family practice, general internal medicine, or general practice. Very few osteopathic physicians practice in North Carolina. We did not include physical therapists as primary care givers for patients with acute back pain, since such patients rarely seek care from a physical therapist first.⁸ None of the neurologic surgeons who were selected saw a substantial number of patients with acute low back pain. Since few orthopedic surgeons practice in rural areas, we did not divide this group into rural and urban practitioners.

Practitioners were eligible to participate in the study if they provided ambulatory care more than half the time and saw patients with acute low back pain who had not been referred by other providers. The practitioners were aware of the overall purpose of the study but not of the specific outcome or utilization variables. On average, 74 percent of the eligible practitioners

invited to participate in the study agreed to do so, ranging from 65 percent of the primary care providers to 87 percent of the HMO and orthopedic providers. A total of 208 practitioners participated in the study: 39 urban primary care practitioners, 48 rural primary care practitioners, 32 urban chiropractors, 32 rural chiropractors, 29 orthopedic surgeons, and 28 physicians and nurse practitioners or physician's assistants in a group-model HMO.

Patients

The practitioners invited consecutive patients with acute low back pain to participate in our study. The criteria for enrollment included back pain of less than 10 weeks' duration, no previous care received for the pain, no history of back surgery or cancer, and no pregnancy at the time of the initial visit. In addition, the patient had to have a telephone and speak English.

The practitioners obtained consent from the patients and recorded basic information from the history and physical examination at the initial office visit. Staff members of the University of North Carolina Survey Research Unit performed all interviews. The study was observational, and we made no attempt to influence the practitioners' decisions about diagnostic tests or treatments. Staff members in each practice kept a list of patients recruited for the study, allowing an assessment of approximate recruitment rates. Fifty percent of patients with back pain seen by the practitioners were eligible for the study, and only 8 percent of those who were eligible declined enrollment. The main reasons for ineligibility were chronic pain and previous treatment for the current episode of pain. Patients were paid \$20 for the time they spent answering interview questions. They were told that the purpose of the study was to determine how long back pain usually lasts and the types of treatments used. Members of the Survey Research Unit contacted the patients by telephone shortly after the index office visit. The median time from the index visit to the base-line telephone interview was seven days.

Outcomes

Information on demographic characteristics, use of health care services, and functional sta-

tus was collected at the time of the base-line interview and at 2, 4, 8, 12 and 24 weeks or until the patients declared themselves "completely better."

The primary outcome was the date of return to a functional status equivalent to that before the onset of pain. At each interview, patients were asked whether they had returned to their previous functional status. In addition to that question, we asked patients whether they had completely recovered from their back pain (i.e., whether they were "completely better"). We measured the functional status at each interview with the Roland-Morris adaptation of the Sickness Impact Profile, a 23-item validated scale that specifically assesses loss of function due to back problems.^{9,10} We also assessed the patient's work status at each interview. Satisfaction with care, determined with the use of a questionnaire designed for a previous study of back pain,¹¹ was assessed at the interview during which the patient reported complete recovery or at 24 weeks, if the patient had not previously reported complete recovery.

Telephone surveys were used to record all the care received from all providers. Detailed

information about the care received from the index provider was obtained from patient records, and this information correlated well with that reported by the patients. Data on the charges for outpatient services were based on average statewide charges assigned by a large health insurance carrier. The charges were specific for the specialty. For example, lower charges were assigned to lumbar radiographs obtained by chiropractors than to those obtained by medical doctors.

Charges for medication were calculated as the average wholesale cost to the pharmacist plus 40 percent.¹² We assumed a two-week course of medication at each interval in which the patient took medication. The categories of care for which charges were assigned included office visits, radiography and other imaging studies, medication, physical therapy, and other modes of treatment. Charges by chiropractors largely represent the last category. Additional information on assigned charges is available on request. To compare charges in the HMO stratum with those in the other strata, we assigned charges to units of care provided by the HMO practitioners, using the same decision rules that

we used for the other strata.

We examined bivariate relations between the type of practitioner and each outcome variable, using a one-way analysis of variance or the Kruskal-Wallis test¹³ for continuous data, Pearson's chi-square test for categorical data, and nonparametric Kaplan-Meier methods for data on the time to functional recovery. These bivariate analyses were followed by multivariate analyses. A Cox proportional-hazards model was used to estimate the time to functional recovery, with adjustment for covariates that might confound the

CHARACTERISTIC	PRIMARY CARE PHYSICIAN		CHIROPRACTOR		ORTHOPEDIST	HMO PROVIDER	P VALUE*
	URBAN	RURAL	URBAN	RURAL			
No. of patients	278	366	310	296	181	202	
Mean age (yr)	41	43	40	44	40	38	<0.05
White race (% of patients)	82	84	84	92	85	65	<0.05
Male sex (% of patients)	44	43	50	55	52	42	
Family income <\$20,000 (% of patients)	27	47	27	33	27	19	<0.05
First episode of back pain treated by professional (% of patients)	56	57	54	38	56	50	<0.05
Sciatica (% of patients)	21	27	28	23	26	15	<0.05
Duration of episode <2 wk (% of patients)	66	71	64	66	59	68	
Mean functional-loss score†	10.3	12.7	11.7	9.9	11.7	10.4	<0.05
Workers' compensation (% of patients)	34	40	25	23	38	26	<0.05
Mean pain score‡	5.3	5.6	5.2	5.3	5.4	5.6	

*The P values are for differences among the strata. Only significant P values are shown.

†Functional loss, measured with the Roland-Morris adaptation of the Sickness Impact Profile, was measured on a scale of 0 to 23.

‡Pain was assessed on a scale of 1 to 10.

Table 1. Base-line characteristics of patients with acute back pain seen by various types of providers.

relation between the type of practitioner and functional recovery. Logistic regression was used for analyses with dichotomous variables. Probabilities and 95 percent confidence intervals were calculated on the basis of model-estimated beta coefficients and standard errors. Multiple linear regression was used to estimate adjusted mean differences in continuous variables among the six strata. Because the cost data were skewed, we modeled charges in three ways: by studying the actual dollar amounts, the log-transformed values, and the rank order of charges. Beta coefficients and standard errors were used to calculate adjusted means and 95 percent confidence intervals.¹⁴ For all analyses, we corrected the standard error for any intragroup correlation due to the cluster sampling scheme.¹⁵ Standard statistical software packages (SAS and Stata) were used for the analyses.^{16,17}

Results

From June 1992 to March 1993, a total of 1633 patients were enrolled in the study. The clinical and demographic characteristics of the patients in the six strata were generally

similar, although there were statistically significant differences for a number of variables (Table 1). The patients were relatively young, and a substantial minority had sciatica. Workers' compensation was involved in 31 percent of the cases. In each stratum, 59 percent or more of the patients had acute back pain of less than two weeks duration. Overall, patients had rapid improvement, with a median of 8 days and a mean of 16 days to functional recovery (a return to a functional status similar to that before the onset of low back pain). Only 5 percent of the cohort had not reported functional recovery by the end of the six-month study period. Functional recovery, estimated to the nearest day by the patient, corresponded to an improvement in the disability score on the Roland-Morris scale (from 11 to 4.1). The strongest predictor of a delay in the return to normal functioning was a high level of functional impairment at base line. A nonparametric Kaplan-Meier analysis revealed no clinically significant differences in the time to functional recovery among the six strata. A Cox proportional-hazards model adjusted for the duration of pain before the initial visit, the presence or absence of sciatica, functional status at the base-line interview, family income, status with respect to workers' compensation, and educational level confirmed this finding (Figure 1). Restricting the analysis to patients who were seeking care for back pain for the first time did not change the findings. The power to detect a 10 percent difference in the rate of functional recovery at two and four weeks was greater than 95 percent.

We also asked patients at each interview whether they were "completely better." For each interval between interviews, we calculated the proportion of patients who had reported complete recovery. Logistic regression was used to determine the effect of the type of provider on the probability of complete recovery at each interval, with an adjustment for clinical and demographic covariates. Thirty-one percent of the patients did not consider themselves completely better at the end of six months. Differences in the probability of recovery according to the type of provider were of borderline significance at

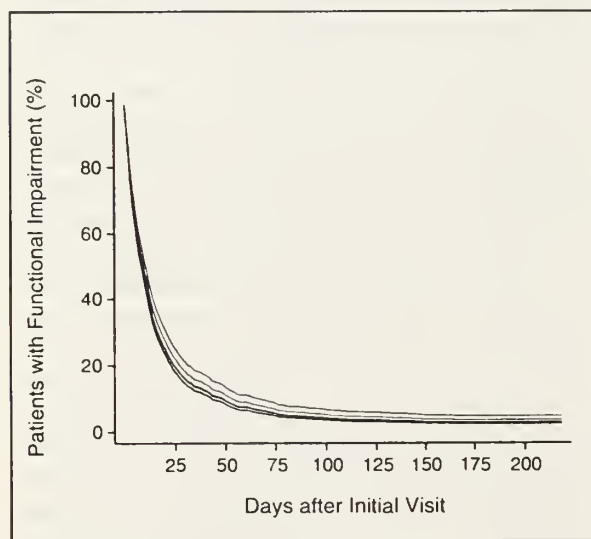


Figure 1. Cox-Model curves of the time from the initial visit to back pain treated by various types of providers. The confidence intervals overlap (data not shown), with no statistically significant differences among the six strata. Data have been adjusted for base-line differences in functional status (the Roland-Morris score), the presence or absence of sciatica, income, duration of pain before the index visit, workers' compensation status, and educational level. Because of overlap, not all of the six curves are visible.

SERVICE	PRIMARY CARE PHYSICIAN		CHIROPRACTOR		ORTHOPEDIST	HMO PROVIDER	P VALUE
	URBAN	RURAL	URBAN	RURAL			
Visits to index provider (mean no.)	1.9	2.0	13.2	9.0	2.2	1.9	0.001
Visits to any provider (mean no.)	4.4	4.6	15.0	10.1	5.5	3.1	0.001
Radiography of the spine (% of patients)	26	32	67	68	72	19	0.001
CT or MRI (% of patients)	9	11	8	7	17	6	0.004
Medications (mean no.)	3.3	3.7	2.4	2.1	3.6	3.3	0.001
Hospitalization (% of patients)	3	4	2	3	6	1	0.017

*P values are for differences among the strata, according to Pearson's chi-square test with 5 df for categorical data and a one-way analysis of variance with 5 df for continuous data. CT denotes computed tomography, and MRI magnetic resonance imaging.

Table 2. Use of health care services among the six strata of providers.

base-line and two weeks and not significant at 4,8,12,24 weeks. After adjustment for base-line variables, there were no significant differences among the six strata in the estimated mean disability scores on the Roland-Morris scale. Patients who reported functional impairment continued to have high disability scores.

In the three-month period before the index office visit, 84 percent of the patients were employed. At the time of the base-line interview, the mean number of days of work missed in the previous month because of back pain was 2.9. Over 95 percent of the patients were back at work by the four-week interview, with no differences among the strata.

We used patients' reports and records to estimate the number of visits to providers. If a patient initially saw an urban primary care physician and had two subsequent visits with that physician, plus one visit to a physical therapist and two visits to an orthopedic surgeon, the total number of visits assigned to the primary care physician was six. The data presented are unadjusted; adjustment for the base-line variables did not substantially affect the results.

The mean number of visits differed substantially among the strata (Table 2), ranging from 3.1 in the HMO stratum to 4.4 and 5.5 in the primary care and orthopedic strata, respectively. The mean number of visits among the patients seeing chiropractors was 10.1 in the rural stratum and 15.0 in the ur-

ban stratum. Although the most common treatment used by chiropractors was spinal manipulation, additional treatments included heat, cold, diathermy, ultrasonography, electrical stimulation, and traction.

The average number of prescription or over-the-counter medications used was higher among the patients seen by primary care physicians, orthopedists, or HMO providers than among the patients seen by chiropractors (3.5 vs. 2.3 medications, $P < 0.001$). The

number of medications was similar among the primary care, orthopedic, and HMO strata. The patients who saw chiropractors took an average of 0.7 prescription medication during the episode of back pain, as compared with 1.9 prescription medications taken by the patients who saw primary care, orthopedic, or HMO providers. The most common medications were acetaminophen, over-the-counter non-steroidal antiinflammatory agents, prescription nonsteroidal antiinflammatory agents, muscle relaxants, and narcotic agents.

Plain spine radiographs were used more frequently by the chiropractors and orthopedists (in 67 to 72 percent of the patients) than by the other groups of providers. There were

STRATUM	COST PER EPISODE (\$)		
	MEAN (95% CI)	ADJUSTED MEAN (95% CI)*	MEDIAN (95% CI)
Urban primary care provider	478 (381-575)	508 (418-598)	169 (141-207)
Rural primary care provider	540 (455-625)	474 (394-555)	214 (193-245)
Urban chiropractor	808 (717-900)	783 (698-868)	545 (487-611)
Rural chiropractor	554 (461-648)	611 (524-698)	348 (299-378)
Orthopedist	809 (688-930)	746 (633-858)	383 (352-436)
HMO provider	365 (250-479)	435 (328-542)	184 (165-214)

*The 95 percent confidence intervals were calculated according to the method of Conover.¹⁴ CI denotes confidence interval.
†Adjustments were made for base-line functional status, sciaticea, income, duration of pain, and workers' compensation.

Table 3. Total direct outpatient costs per episode of low back pain.

no statistically significant differences in the use of radiographs among the three primary care strata. Computed tomography and magnetic resonance imaging, which were used in all strata, were used most frequently in the orthopedic stratum and least frequently in the HMO stratum.

Hospitalization rates were low in all six strata. The overall rate was 3.5 percent. Only one patient in the HMO stratum was hospitalized.

We estimated the charges for outpatient care in each of the six strata (Table 3). Both unadjusted and adjusted data are presented. Because of the low number of hospitalizations, we focused on outpatient charges. Chiropractors and orthopedists had the highest charges. The chiropractors' charges were high because of the use of radiographs and the large number of office visits, which more than made up for the low charge per visit. The orthopedists' charges were high because of the high charge per visit, use of diagnostic procedures, and use of physical therapy.

The distribution of charges per episode of back pain was highly skewed, with a small proportion of patients (6 percent) who had outpatient charges exceeding \$2000. The median charge per episode, which is less subject to the effect of these outliers than the mean charge, shows the same pattern, with higher median charges in the strata of orthopedists and chiropractors (Table 3). Charges in the

three primary care strata were very similar. The HMO stratum had fewer outliers than the other strata (3 percent of the HMO patients had charges exceeding \$2000). Log transformation and nonparametric tests yielded a similar pattern.

During the interview at which the patient reported complete recovery or at the six-month interview, for those who did not report complete recovery the patients were asked about their overall satisfaction with the care they had received. Patients who saw chiropractors reported a significantly higher degree of satisfaction than those who saw practitioners in the other four strata (Table 4). A logistic-regression analysis showed that the patients who saw orthopedic surgeons were somewhat more satisfied than the patients who saw primary care providers but were less satisfied than those who saw chiropractors. The higher level of satisfaction among the patients who saw chiropractors persisted after adjustment for the number of visits and the use of radiography. The strongest correlates of satisfaction were the patient's responses to questions about the quality of the provider's history taking, examination, and explanation of the problem during the visit (Table 4).

Discussion

In this study of acute low back pain, only 5 percent of the patients had not reported functional recovery at six months. However, 31 percent of the patients had not completely recovered at six months, which indicates that low-grade disability may last longer than previously thought. A study conducted at an HMO yielded similar results.¹⁸ Whether the patient saw a primary care physician, a chiropractor, or an orthopedic surgeon as the initial provider, the time to recovery from the acute back pain was essentially the same.

Primary care physicians appear to offer efficient outpatient treatment, with some evidence that the most efficient care may be provided in a group-model HMO. Although charges per radiograph and per visit are lower for chiropractors than for medical doctors, the much higher number of treatments given by the chiropractors (requiring a larger number of

VARIABLE	PRIMARY CARE, ORTHOPEDIC, OR HMO PROVIDER	CHIROPRACTOR	P VALUE
No. of patients	1027	606	
<i>% of patients</i>			
Satisfaction with care (% answering "excellent")			
Information given?	30.3	47.1	<0.001
Treatment of back problem?	31.5	52.1	<0.001
Overall results of treatment?	26.5	42.1	<0.001
Perception of care (% answering "yes")			
Detailed history of back pain taken?	68.4	88.4	<0.001
Careful examination of back performed?	79.9	96.1	<0.001
Cause of problem clearly explained?	74.6	93.6	<0.001

Table 4. Patients' satisfaction with and perception of care.

visits) more than offsets this apparent advantage. For acute low back pain, the best care may be minimal care.

Our finding that the higher charges by chiropractors reflected a larger number of visits per episode of back pain is similar to the result of a secondary analysis of data from the Rand Health Insurance Experiment, performed by Shekelle, et al.¹⁹ They reported a mean of 10.4 visits to chiropractors per episode, as compared with 2.3 visits to primary care physicians.

Our study was observational; patients were not randomly assigned to the various types of providers. A randomized trial would be very difficult to perform in a community setting. Since the patients in our study were enrolled at the time of the initial office visit, we could not assess their functional status before the episode of back pain. The outcomes of care provided by practitioners who rarely serve as first-contact providers (e.g., physical therapists and rheumatologists) could not be assessed. In addition, our analysis of charges relies on estimates, but the differences among the strata of providers were substantial.

Several studies have reported improved outcomes among patients undergoing spinal manipulation, as compared with those receiving medical treatments.²⁰⁻²⁴ Our study did not confirm these results. Several explanations are possible. There may have been a benefit from spinal manipulation, but uncontrolled confounding due to unmeasured differences in the case mix may have obscured this effect. The differences among the strata in our study were actually smaller after adjustment for the presence of sciatica, the duration of pain, and functional status, indicating that significant differences in recovery rates among the strata would have been unlikely after a further adjustment for case mix. Alternatively, the treatment provided by the randomly selected chiropractors in our study may not have been as effective as the treatment provided in the trials in which the intervention was standardized.

Do our findings simply reflect the natural history of acute low back pain, with essentially no modification by medical or chiropractic care? Since our study did not

include a group of patients who sought no care for their acute back pain, we cannot answer this question. Improved techniques of self-care should be investigated. Acute back pain is sufficiently disabling, however, that many persons will continue to seek professional care.

Our finding that the patients in the chiropractic strata were more satisfied with their care than the patients in the other strata is consistent with the results of a previous study by Cherkin and MacCornack.¹¹ Multiple outcome measures (the time to functional recovery and return to work, the time to complete recovery, and functional status) were similar in the chiropractic and physician strata, yet the patients seen by chiropractors reported greater satisfaction with the examination and explanation of the problem. Patients and insurers need to address the trade-off between the substantially lower charges by primary care practitioners and the higher level of satisfaction with the care that chiropractors and orthopedic surgeons provide.

Our study has implications for health care policy. The costs of acute back pain are substantial. Previous studies by our group have shown that 3 percent of the North Carolina population seek care for acute low back pain each year.⁸ It is important to compare the effectiveness of short and long courses of spinal manipulation. Since the choice between specialists and doctors of chiropractic as primary providers of care is not associated with a difference in the functional outcome, the marginal costs (i.e., for increased care without an improvement in function) are very high. Although medical researchers should continue to seek more effective therapies for acute back pain, the continued use of marginally effective therapies and expensive, low-yield diagnostic tests has led to a level of health care utilization that probably cannot be sustained in an era of increasingly limited resources.

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Quality, Care and Service Since 1958

Family Physicians, Chiropractors, and Back Pain

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In a commentary on back pain in *The Journal of Family Practice* in 1988, Dan Cherkin wondered why there had been so little study of this problem by family physicians, and whether this was attributable to their satisfaction with current approaches to care or to frustration over their inability to modify the course of the illness.¹ In this country, low back pain, dysfunction, and work disability are moving toward epidemic proportions, and the context in which back problems occur most often results in presentation to primary care physicians, particularly family physicians. However, another discipline, chiropractic, is playing an increasing role in the primary care of musculoskeletal problems. Family physicians should therefore re-evaluate their relationship with these health care providers.

Manpower Issues

Back pain is the second leading reason reported by patients for visiting physicians.^{2,3} Every year nearly 13 million visits are made to physicians for chronic low back pain, and it is the second leading cause of work days lost.^{3,4} From 1971 to 1981, the number of disabled people and the costs of care for low back pain increased at a rate 14 times that of the population growth.³ In medical settings, family physicians care for 38.6 percent of the patients with acute and chronic back pain, compared with 36.9 percent seen by orthopedists, 16.9 percent by osteopaths, and 7.6 percent by internists.⁵ Back symptoms are the

third most common reason for visiting a family physician.⁶

Chiropractors account for about twice the number of visits for back pain as physicians.^{7,8} In an eight-year community-based survey of six sites in different parts of the country, Shekelle and Brook⁸ reported that 7.5 percent of the population made at least one visit to a chiropractor; 42.1 percent of the visits were for back problems and 10.3 percent for neck problems. Manipulation accounted for 66 percent of repeat visits.

Thus, in terms of musculoskeletal problems, family physicians and chiropractors provide the majority of ambulatory care in the health care system. They tend to serve similar populations and yet their services do not seem to be in competition with each other.⁸⁻¹⁰ Certainly both groups have grown in numbers over the past 20 years.^{9,11} There are at least 20,000 registered chiropractors in the United States who treat over 7.5 million people each year with services covered by Medicaid, Medicare, and government-employee and private insurance, as well as state worker's compensation.¹²⁻¹³

Perspectives on Back Care

In a series of reports based on physician, chiropractor, and patient surveys, Cherkin and colleagues¹⁴⁻¹⁶ offered some interesting insights on the management of back pain by these professionals. In a study of health management organization (HMO) and non-HMO settings, 50 percent of family physicians surveyed believed they were only slightly or not at all informed about the clinical scope and skills of chiropractors, although 26 percent

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saw them as an excellent source of care for certain musculoskeletal problems. The latter group tended to be the younger family physicians who were also the most knowledgeable about chiropractors, and more likely to have encouraged patients to see them.

Patient perspectives from another well-designed study restricted to an HMO population indicated significantly greater satisfaction with chiropractic care than with family physician care.¹⁶ Items of back care provided by family physicians with which patients were not very satisfied were: information about the cause of pain; advice on recovery time and how to manage the problem; and instruction on posture, exercise, and lifting skills. Patients believed that family physicians were less confident and comfortable in their diagnosis and management and showed less concern and understanding of their problem than chiropractors. The number of days of disability for patients seen by family physicians was significantly higher (mean 39.7) than for patients managed by chiropractors (mean 10.8).

What were the chiropractors doing right and what were the family physicians doing wrong? Although not based on randomized controlled interventions, these data suggest that family physicians were not able to provide as clear or rational an explanatory model of the problem to the patient as the chiropractors. In addition, they did not individualize management as well. These issues, as well as the possible value of hands-on manual therapy, could be addressed by additional training and education in musculoskeletal disease either during or after residency training.

There is some evidence from a handful of controlled trials that spinal manipulation does have a beneficial effect for low back pain, particularly for certain sub-groups of patients with more chronic or recurrent problems.¹⁷⁻²¹ On the other hand, in a recent meta-analysis of 35 randomized trials of spinal manipulation, only 51 percent of the studies showed an improved short-term outcome. Most of these studies had methodological problems, not the least of which were patient selection bias and difficulties of standardized

diagnosis.²² Other forms of treatment, including physical therapy and facet injections, have also been shown recently to be of little or no benefit, probably for the same reasons.^{23,24} Treatment is generally palliative and not curative. Setting specific therapies aside, there are other issues raised in these studies.

Cherkin et al¹⁴ suggest that the beliefs of family physicians that no specific diagnosis for back pain exists other than "back strain" and "slipped disc," and that there is little effective treatment other than expectant analgesia, lead to frustration and therapeutic nihilism. The same investigators have recently reported on a targeted continuing medical education (CME) program designed to improve back care and patient satisfaction.²⁵ The primary goal was to increase physician comfort and confidence in managing back pain. Although an increased feeling was noted on the part of the physicians that their patients were more satisfied and reassured about their problem, a survey of the patients seen by the above physicians showed that the intervention had no effect on outcomes of care.²⁶ Cherkin, et al suggest, after reviewing several options, that negative feelings about back pain patients induced early in medical training may override other determinants in back care outcome. This may be subconsciously or openly conveyed to patients creating a negative placebo effect.¹²

Positive placebo effects derive from agreement between patient and provider on the nature and cause of the problem, strong assurance on outcome, the use of instrumentation, and the "laying on of hands."^{12,27,28} In their recent paper, Koes, et al²³ comment on the power of the placebo and the possibility of beneficial effects of referral to another professional. Placebo modulation of pain through segmental reflexes as well as cortical and limbic activity through the hypothalamus is well substantiated by the gate-control theory developed by Melzack and Wall in 1965.²⁹ Furthermore, Waddell³⁰ has shown that, for chronic low back pain, physical pain contributes only 40 percent, whereas psychological distress and abnormal illness behavior contribute 31 percent to the degree of disability, although the contribution by illness behavior

may be significantly less for patients with acute back pain. Back pain, therefore, provides a classic example of the bio-psychosocial model of illness in which social and psychological factors play major roles in pain control, disability, and rehabilitation. Yet the tools commonly used by family physicians to treat back pain tend to be those of biomedicine and referral rather than behavioral and direct manual therapy, and this may explain why patients are more satisfied with care from chiropractors, who are much more focused on musculoskeletal problems and the context in which they occur.^{6,14}

Referral to Chiropractors

Over the last 50 years, allopathic medicine has had a deep suspicion and concern about chiropractic. Until 1980, the American Medical Association stated that it was unethical to refer a patient to a chiropractor, and a physician doing so was likely to lose membership in the association. National chiropractic associations were only able to achieve full acceptance as a clinical discipline through winning a historic lawsuit against the American Medical Association, which was found to have conspired with other groups to contain and eliminate chiropractic through ethical prohibitions.³¹

Many physicians, probably a majority, are still reluctant to make specific referrals to osteopaths or chiropractors. In a survey of a 25 percent random sample of chiropractors in 1973, respondents indicated that 90 percent referred patients to physicians and 65 percent received referrals from physicians.³² A 1986 survey of a sample of patients attending 10 chiropractic clinics¹⁹ indicated that 53 percent had consulted a physician during the current episode of pain and 19 percent had been referred to the chiropractor by the physicians; but a more recent study⁸ reported that less than 1 percent of patients were referred to chiropractors by other providers. Some guidelines on identifying a competent and ethical chiropractor are shown in Table 1.

There are many complex factors of history, attitude, belief, and professional distrust that contribute to this discrepancy in

- Treats mainly musculoskeletal disorders with manual manipulative techniques
- Does not do routine radiographs on every patient
- Does not extend duration of treatment unnecessarily (see Table 2)
- Writes a response to a referral and outlines evaluation and therapy
- Does not charge "front end" lump sum for whole treatment program
- Graduated from a school accredited by the Council on Chiropractic Education
- Is willing to have physician visit the office to observe treatment
- Good feedback from patients on care given

Table 1. Guidelines for identifying a competent chiropractor.

behavior between the professions.³³ Probably the most powerful perceptions noted by allopathic physicians involve suspicion regarding the extent, depth, and validity of manipulative training, particularly the possibility of "missing" a serious disease. Since the early part of the century, however, chiropractic schools have required a minimum of four years of training that includes medical basic sciences, general diagnostics, radiology, physical therapy, and, of course, manipulative therapy, with prerequisite coursework similar to that necessary to enter medical school. In 1979, a commission of inquiry found the basic sciences at North American chiropractic schools to be equivalent to those taught at medical schools.³⁴ Currently, a typical curriculum involves a minimum of 4200 hours of training, of which approximately 1200 hours are patient contact.³⁵ Doctors of Chiropractic are highly trained practitioners, qualified and licensed to diagnose disease entities and to refer patients when the treatment necessary is out of their scope of practice.

Another argument against the use of chiropractic is the perceived lack of basic scientific evidence and clinical trials that would justify the use of not only manipulation but other mechanical and electronic devices. Although there is a considerable amount of neurophysiological research supporting the theoretical basis of manipulative therapy, basic scientific evidence and clinical trials dealing with this topic are scarce, as they are for

other modalities used in the treatment of musculoskeletal ailments.^{18,22,24,28}

Finally, there is the argument that manipulation is a dangerous intervention.¹² Over the years, there has been some justification for these views as a result of unsupported claims for success in treating a range of medical conditions.³⁶ The dangerous complications of manipulative techniques, mainly vascular accidents, occur in very small numbers (about 113 documented cases) and have been used as a weapon against chiropractors.^{37,38} The incidence of vascular accidents following cervical manipulation has been reported as between 1:400,000 to 1:1,000,000 procedures.^{39,40} Almost all complications of manipulative therapy have involved specific rotary adjustments of the cervical spine, which comprise about 30 percent of the 100 million visits per year made to chiropractors.^{41,42} In fact, a number of these complications have followed manipulations by allopathic physicians.³⁶ Complications of lumbar spine manipulation are even more rare and usually consist of an exacerbation of radiculopathy with a herniated disc.³⁶ However, certain clinicians have used manipulative therapy specifically for lumbar disc herniation.⁴³

What Is Manipulative Therapy?

For chiropractors, manipulative therapy is the art of restoring a full and pain-free range of motion to joints. The theoretical basis is that hyper- or hypomobile joints produce local and distant effects as a result of abnormal afferent and efferent nerve irritation from joints, synovial membrane, and other soft tissues. The ability to perform manipulative therapy is not easily attained. The communication skills and sensitivity of the hands to appreciate tissue compliance and subtle joint movements take some time to develop. Manipulation is generally performed by taking joints to their end point of motion ("long lever" technique) and then isolating the joint to be manipulated by local pressure on prominences of the articulating bones within the stretched area ("short lever"). Once isolated, a high-velocity but low-amplitude thrust is delivered to the joint, and an audible noise usually signifies that the manipulation has

been successful. Done properly, the procedure is painless and the joint has moved past its passive range of motion but not outside of its range of anatomical integrity.³⁵ It should be obvious that the techniques, broadly described here, should not be performed by those who are not adequately trained. It should be noted that chiropractors also provide physical therapy, perform radiographic examinations, and advise their patients about diet and exercise. These adjunct therapies are said to promote more rapid recovery than manipulation alone but have not been proven to be of benefit.

Contraindications and Indications for Referral for Manipulative Therapy

Contraindications for referral for manipulative therapy include a range of systemic diseases, including arthritis; bone disease such as infection or metastases; long-term steroid therapy; evidence of significant cardiovascular disease; anticoagulation; vertigo; neurologic disease; severe cervical spondylosis; and disc lesions with objective neurologic deficits.^{36,44} Less than 1 percent of all low back pain patients have an underlying systemic disease as a cause, however, and almost all can be screened by radiograph and sedimentation rate by applying the criteria established by Deyo⁴⁵: presence of neurologic deficit; age over 50 years; presence of fever, weight loss or adenopathy; steroid use; evidence of rheumatoid or ankylosing spondylitis; prior malignancy. These risk factors are rarely absolute; both of us have treated patients from each of the aforementioned categories, after accurate diagnosis and special considerations have been made. Thus, a patient with breast cancer may still suffer from mechanical back pain, and manipulation can be effective as long as bone metastases have been excluded.

Chiropractors are highly trained in musculoskeletal diagnosis and treatment techniques and are found in many of the same practice locations as family physicians. Their popularity and presence has increased, and in all states their services are covered by insurance and worker's compensation.⁴⁴ Because of the significant economic and

professional impact of this form of treatment, interest in the validation of manipulative therapy has grown.

Recently, the RAND Corporation, in conjunction with the UCLA Division of General Internal Medicine and the Foundation for Chiropractic Education and Research and the Consortium for Chiropractic Research, used the modified expert panel technique to assess the appropriateness of spinal manipulation for low back pain.⁴⁶ This evaluation reviewed manipulation in general rather than specific chiropractic techniques. The results provide some guidance to family physicians in the referral of patients with low back pain to chiropractors and assist them in educating patients on what to expect in terms of treatment duration. The panel included a number of nationally recognized expert clinicians and researchers in back pain from the disciplines of orthopedics, medicine, family medicine, sports medicine, and chiropractic. A wide and exhaustive range of back-pain scenarios were rated by the panel by degree of appropriateness based on probable benefit, and were scored in terms of agreement, disagreement, or equivocation by the panel. The major agreed upon clinical profiles that would *most likely* benefit from manipulation are shown in Table 2.

Summary

The scientific evidence accumulated to date does not clearly indicate that spinal manipulation is beneficial, although most of the studies had flawed methodologies. In terms of return to normal function and patient satisfaction, chiropractic therapy seems to be of value. This may be the result of one or more factors: an effect of manipulation, a different approach to working with a patient, or a placebo effect. Indeed, the referral process itself may have an effect on patient outcome.²³

Family physicians could certainly benefit from reevaluating their approach to back pain by addressing issues of a more organized concept of diagnosis, the biopsychosocial model of illness, and the judicious use of the placebo effect.

Deciding which patients should be referred to a chiropractor requires careful con-

Problem	Duration of Treatment†
Acute low back pain (<3 wk) Previous good response to manipulation Normal or abnormal radiographs Radicular pain None or minor neurologic signs	3 to 5 treatments, maximum of 10 before reevaluation
Subacute low back pain (3–12 wk) Previous good response to manipulation Normal or abnormal radiographs No neurologic signs	Unclear
Chronic low back pain (>3 mo) Previous good response to manipulation Normal radiographs/imaging No neurologic signs	3 treatments/wk for up to 8 wk before reevaluation

*Adapted from RAND study.⁴⁶

†Estimates, not consensus.

Table 2. Clinical profiles appropriate for manipulation.

sideration. A favorable prior response to manipulation is a good sign that treatment may help again. Using the expert-panel approach, the guidelines reported here begin to define for primary care physicians (as well as the health insurance industry) the indications and time frames for manipulative treatment and recovery that patients can expect from chiropractors and osteopaths. The expert-panel approach relies on literature review and complex consensus development. Ideally, these data and recommendations should be acquired using prospective randomized intervention studies. This would be an important and expensive undertaking, but worthwhile given the huge cost of back care in this country.

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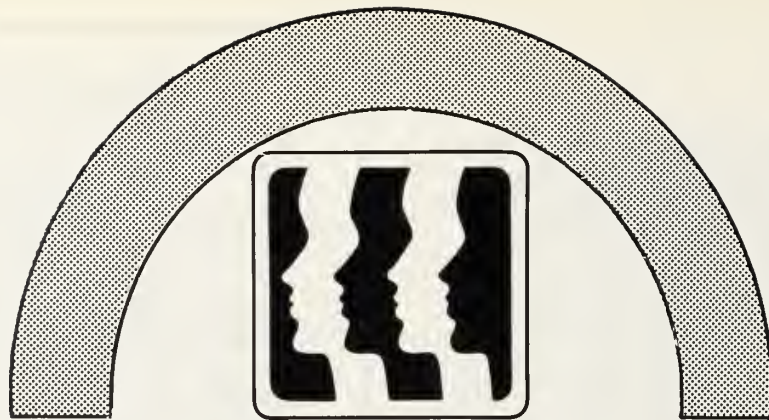
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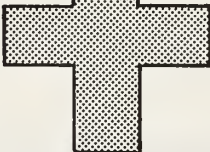
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Recent Advances in the Diagnosis of Breast Cancer: Scintimammography

Steven L. Edell DO FACR

Breast cancer is one of the most common malignancies in American women, second only to lung cancer. The American Cancer Society reported that in 1993, 182,000 women were diagnosed with breast cancer and 46,000 died from this disease. Mammography has long been the gold standard in the diagnosis of breast cancer, although it is not perfect. The estimates range from 80 to 90 accuracy with further inaccuracies in younger women or those with denser and more fibroglandular breast tissue. The low specificity (15 to 30 percent for nonpalpable tumors)¹ and low positive predictive value (only 22 percent for palpable carcinomas)² for mammography has led to multiple biopsies revealing benign forms of the disease. The difficulty in detecting benign from malignant lesions with mammography has encouraged other imaging modalities to emerge. High-resolution ultrasound has been extremely helpful in differentiating simple benign cysts from solid lesions with an accuracy of almost 100 percent but is less successful in differentiating benign from malignant solid lesions.³ Contrast-enhanced MRI has recently gained acceptance in the detection of breast cancer with a recent study reporting a sensitivity of 94 percent in demonstrating disease but a specificity of only 37 percent in confirming malignant lesions.⁴ MRI has been more helpful with its negative predictive value for excluding disease as well as its ability to detect multi-centric and multi-focal cancers.

Scintimammography has recently emerged as a promising imaging modality in the detection of breast cancer and evaluation of regional lymph nodes. Over the past decade, numerous studies have been reported on the accuracy of Thallium 201 scintigraphy for the detection of many tumors, including those of the brain, thyroid and parathyroid as well as breast cancers. In one recent study, Waxman evaluated 81 patients, with 96 percent of the palpable breast cancers detected using Thallium 201 scintimammography.⁵

More recently, another cardiac-isotope, Technetium 99m Sestamibi (cardiolite), was discovered to have similar tumor-imaging properties with better resolution than Thallium 201. Numerous recent studies have confirmed the success of Technetium 99m MIBI in detecting breast cancer with a sensitivity of approximately 96 percent and specificity of approximately 87 percent. More importantly, however, has been the 97 percent negative predictive value with scintimammography.⁶ This negative predictive value makes it an excellent screening technique over conventional mammography for excluding the presence of breast cancer. More than 1000 patients with breast cancer have been studied with Technetium 99m MIBI. The largest study by Jochelson comparing mammography to MIBI showed sensitivity and specificity for mammography of 82 percent and 50 percent compared to 90

percent and 80 percent respectively for MIBI.¹ Other articles have recently been published acclaiming the ability of MIBI to demonstrate regional lymph node involvement, greatly improving preoperative staging.⁸

The latest in the scintigraphic tumor-imaging armamentarium consists of radioimmunoscinigraphy using monoclonal antibodies against various antigens coupled with different isotopes. McEwan, et. al. utilized radioimmunoscinigraphy with MAb-170, derived from the immunization of mice with synthetic TF antigen, to demonstrate a sensitivity of 90 percent and positive predictive accuracy of 95 percent in 53 patients with breast cancer.⁹ The improved resolution of MIBI and the sensitivity and specificity of the newer tagged monoclonal antibodies has increased the accuracy of scintimammography as an adjunct imaging modality to mammography in the detection of breast cancers. This high diagnostic accuracy of scintimammography will allow us to offer our patients a more definitive diagnosis in regard to benign versus malignant breast disease

and will hopefully attempt to lower the unnecessary breast biopsy rate in the future.

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Research?

The scene is in a committee meeting room in Washington, D.C., where the Research Committee is in session. The chair of the committee addresses the applicant.

Chair: We recognize that in your hospital in Delaware no research involving human subjects can be conducted without the approval of your Research Committee. However, because of the national scope of your proposed project, you have been referred to the National Research Committee of the federal government for approval. It appears from the proposal here that people may be endangered and some may even die. Is that correct?

E. Wayne Martz MD

Applicant: Not exactly, sir. Millions will be endangered each year, it is true, but they won't complain. The actual death toll, which we can predict with some accuracy, will be 6,434 additional people in the first year. There is not very much doubt about that, sir.

Chair: That's outrageous! That's more than the total mortality of many types of cancer; more than any epidemic except AIDS. What will the program cost the country?

Applicant: We estimate the cost at about \$19 billion dollars the first year in addition to the unmeasurable costs of grief and family loss.

Chair: Doctor, Congress is at an impasse over the budget for

considerations less than that. Have you no conscience? Where are your professional ethics? There must be some very important considerations to justify such an experiment.

Applicant: Indeed there are, sir! It would give people pleasure and save time when they make long trips by car. For example, on a trip from Wilmington to Bethany Beach, 100 miles, the length of our state, it would save 10 minutes, until you ran into the traffic jam at Rehoboth. Theoretically, it could save as much as 17 minutes. I say "theoretically" because that's the difference between an average speed of 55 and an average speed of 65 for a 100-mile trip (1 hour 32 minutes versus 1 hour 49 minutes).

Chair: What would you propose to do with that 10 to 17 minutes you saved?

Applicant: I would lie down on the beach and smoke a cigarette to recover from the experience, sir.

Chair: I'm sorry, doctor. This committee just cannot endorse the lifting of the 55 mph speed limit cap. It's preposterous! The public would be outraged if we toyed with people's lives that way!

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- March 14** Kent County Membership Coffee, Wild Quail Country Club, 9:30 a.m. - 11:30 a.m. Call Marian Maro at (302) 697-2272 for details.
- March 18** N.C.C. Spring into Fitness. Call Joan Fiss at (302) 654-6604 for details.
- March 30** Osteoporosis Conference (\$10 charge includes lunch), Arsht Hall, Goodstay Center, 9:00 a.m. - 2:00 p.m.
- April 21** N.C.C. Physicians, Spouses and Legislators Get-Together, Academy of Medicine, 5:00 p.m. Dates for Kent and Sussex to be announced.



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MSD MONTHLY ACTIVITIES

Working for You: January 1996

Leadership Activities

- William H. Duncan MD and Beverly Dieffenbach represented MSD at a meeting of the DHCC Certificate of Need committee.
- Mark Meister attended monthly meeting of the Delaware Health Care Commission.
- Stephen R. Permut MD, Phil Corrozi and Mark Meister met with members of the General Assembly regarding the Society's legislative agenda for 1996.
- Michael J. Bradley DO represented the Society at the meeting of the DHCC Primary Care Committee
- Mark Meister represented MSD at the DHCC Health Data committee meeting.
- Drs. Carol A. Tavani, Michael J. Bradley, Anthony Cucuzzella, Stephen R. Permut along with Phil Corrozi and Mark Meister met with representatives of the insurance industry, the Delaware State Chamber of Commerce and the DuPont Company to discuss HB 321.
- Virginia U. Collier MD and Mark Meister attended meeting with Delaware Academy of Medicine representatives to discuss statewide video teleconferencing and telemedicine technology.
- Mark Meister attended the Pharmaceutical Research and Manufacturers of American Annual Invitational Conference for state medical society executives.
- Mark Meister met with senior management from Principal Health Care and Blue Cross Blue Shield of Delaware in separate meetings to discuss current issues regarding managed care.
- Edward Sobel DO and Mark Meister represented the Society at a meeting of the Medicaid Medical Care Advisory Committee.
- Mark Meister met with legislative repre-

sentative for Zeneca regarding pharmaceutical legislation.

- Drs. Tavani, Bradley, Cucuzzella, and S. Grubbs and Mark Meister met with representatives of the Pennsylvania Medical Society to discuss MSO formation for Delaware.

Physicians' Advocate Program Activities

- Consulted physicians' offices regarding practice management and establishment of accounts receivable guidelines.
- Mailed 1996 workshop series brochure to MSD members. Sixteen workshops are being offered this year.
- The Managed Care Contract Review Service concluded in January with the review of the sixth contract - Blue Cross and Blue Shield of Delaware. A letter regarding the 1996 service along with a new enrollment form was mailed out to 94 current participating offices, and offered to MSD membership.

Continuing Medical Education Activities

- Sponsored 18 educational activities for Category 1 credit.

Legislative Activities

- The following physicians served as "Doctor of the Day" on one or more occasions on the days the legislature was in session in January: Robert E. Heckman MD, Michael J. Bradley DO, Donald R. Doran DO, Richard H. Sherman MD, Neil S. Kaye MD, Jorge A. Pereira-Ogan MD, E. Wayne Martz MD. These physicians are members of the Society's Legislative Action Committee, a subcommittee of the Public Laws Committee. The Legislative Action Committee ensures that members of Delaware's General Assembly are informed on medical legislative issues.

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Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting.

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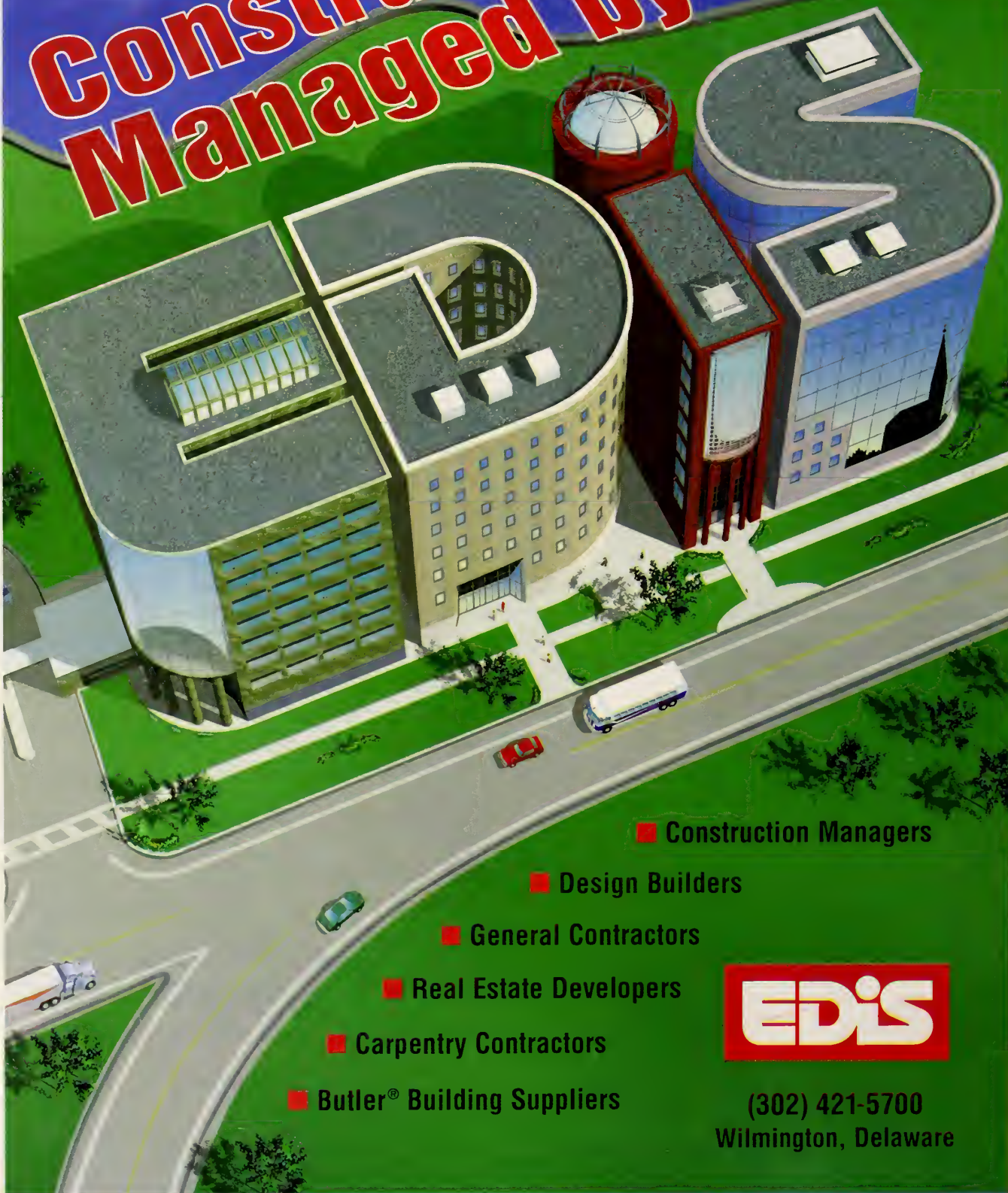
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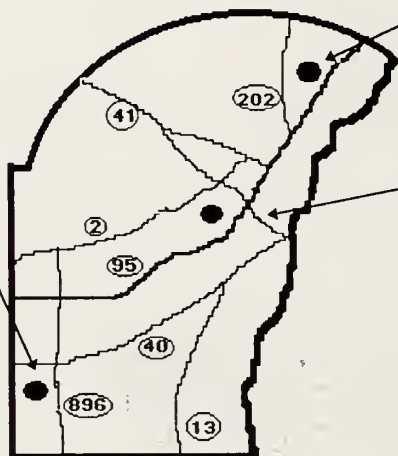
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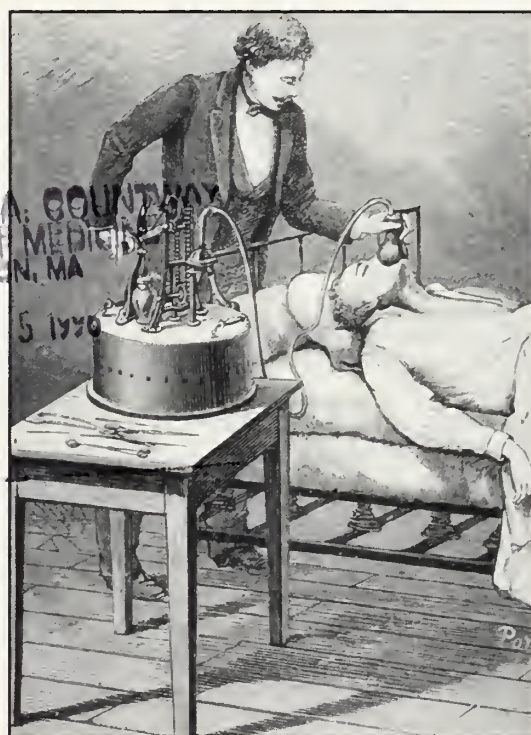
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The Physicians' Advocate

The practice of medicine has evolved into much more than clinical care and the performance of the healing arts. Familiarity with office management, coding, billing, collections, personnel management, insurance issues, and other areas representing the business aspects of practice have become, although many physicians find them distasteful, an inevitable part of daily life. Most physicians have little background in such matters, and find themselves ill-equipped for them; consequently, they learn as they go, often the hard way. I would like to utilize this month's President's Page to apprise the reader that help has arrived, in the form of Jana Siwek and the *Physicians' Advocacy Program*.

The Medical Society launched this program in 1993 to help its members with practice management problems and third party payor issues. Since that time, the services offered have expanded, and this effort has become one of the Society's more successful endeavors. As knowledge of the program has spread, Jana's time commitment has had to be expanded, and her results have been outstanding. Services offered include accounts receivable management consulting; at one practice, wherein receivables were evaluated, staff was trained in collection, and guidelines were developed for managing receivables, the successful collection rate rose to over ninety percent.

Crisis intervention has been most helpful, more than once in the case of loss of key billing personnel. In these cases, temporary billing help was found, and new guidelines for receivables and billing developed; this enabled

the physicians to maintain uninterrupted cash flow and improve their financial procedures in the bargain.

The service is available to orient physicians beginning practice on office procedures, licensing, privileges, insurance panels, personnel management, and billing. Similarly, those contemplating retirement have received assistance in many areas, including how to handle practice records. The feedback from those physicians has been quite positive.

The Contract Review Service (Managed Care Contract Review Service), begun in 1995, has been very popular and well-received. For a nominal fee, the contracts of six major third party payors are reviewed by attorneys and other consultants, with feedback concerning contract changes the physician may wish to consider requesting, explanation of aspects of the contracts, and caveats of which the physician should be aware. In addition, the review assesses the overall fairness of the contract and whether it is likely to work well in a physician's practice.

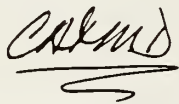
A major project for 1996 has been the creation of a seven-page Physician's Office Guide to Medicaid Managed Care, which has been disseminated to the membership, and is available from the Society.

Last year, a number of workshops were held for physicians and office staff, and that activity has been expanded for 1996. The workshops span all three counties, and include educational sessions on successful collection techniques, how to write a personnel policy manual, OSHA regulations, front desk

customer service, Medicare and Medicaid managed care, how to deal with labor boards and state and federal agencies, and basic and advanced ICD-9 and CPT coding. In addition, several hospital-based inservices and educational programs will again be offered.

In addition to all of the above, in-office practice management consulting is available and includes custom-tailored help in areas such as reducing administrative costs, improving cash flow, managing receivables, processing of workmen's comp claims, and collections, as well as overall review of office operations, front desk procedures, and hiring of personnel (the program offers a resume repository and exchange service). Other projects and offerings are also planned.

The *Physicians' Advocate* may be accessed simply by contacting the Medical Society; we are delighted to offer this service, are very proud of Jana's success stories (which are numerous), and encourage the membership to avail itself of this refreshingly helpful approach to the nuts and bolts aspects of the successful practice of medicine.



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Fertility After Menopause: A Case Report

William F. Ziegler DO

Jeffrey B. Russell MD

Introduction

In-vitro-fertilization (IVF) has opened a new avenue to provide a viable alternative for the treatment of infertility. Utilizing donor oocytes was initially introduced for women with premature ovarian failure.¹ In 1984 the first successful case of IVF with an embryo transfer, with donated oocytes was reported by Lutjen et al.²

The emotional and financial demands of our society have caused an increased number of women to delay childbearing until later life. Therefore, age-related infertility has become an issue and a major challenge for the reproductive endocrinologist. Women over the age of 35 have been reported to have decreased fertility and fecundity.^{3,4,5} Diminished fertility could be a result of uterine factors. Currently, studies have focused on oocyte quality and senescence as a causative etiology.^{6,7} This case report illustrates the feasibility of achieving a pregnancy in menopausal patients utilizing donated oocytes.

Case Report

The patient is a 49-year-old woman, gravida 2, para 1, who presented with a five-year history of infertility. Her obstetrical history revealed a term pregnancy resulting in a vaginal delivery

26 years prior which was followed by an elective first trimester abortion eight years later. The patient noted a decrease in menstrual frequency over the preceding year. Last menstruation was four months prior to the initial visit and a serum follicle stimulating hormone level was in the menopausal range.

She elected to utilize donor oocytes to attempt to achieve pregnancy. Prior to initiating treatment, the couple underwent an extensive medical and psychological evaluation along with a screening physical examination. A hysterosalpingogram was performed to detect any uterine defects. The patient required hysteroscopy after intrauterine adhesions were detected on the hyster-salpingogram. A semen sample was obtained and analyzed for quality, morphology and motility. After the preliminary evaluation was completed, the couple selected an anonymous oocyte donor based on their desired characteristics.

Donor Protocol

The anonymous donor underwent a similar psychological and medical evaluation. The donor underwent an ovulation induction protocol utilizing leuprolide acetate (Lupron, Tap Pharmaceuticals, Chicago, IL), to invoke pituitary down regulation, initiated seven days after ovulation. Controlled ovarian hyperstimulation was performed with urofollitropin (Metrodin, Serono Laboratories, Inc., Randolph, MA) and menotrophins (Pergonal, Serono Laboratories, Inc., Randolph, MA). The

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gonadotrophins were started on cycle day two. Follicular development was monitored with ultrasound measurements from cycle day five to the day of human chorionic gonadotropin (hCG) administration along with serum levels of 17B-estradiol (E2) and progesterone (P4). The gonadotropin dosages were adjusted according to the level of estrogen and follicular maturation. When the donor had at least two follicles measuring 1.8 cm, 10,000 units of human chorionic gonadotropin (hCG) was administered. Transvaginal ultrasound guided oocyte retrieval occurred 36 hours after hCG administration.

Oocyte Recipient

The recipient was synchronized with the oocyte donor utilizing 17B-estradiol (Estrace, Mead Johnson Lab., Princeton, New Jersey), and progesterone to prepare the endometrium for embryo transfer (Figure 1). The recipient was placed on 2 mg of 17B-estradiol twice daily, until the donor had menses. This dosage was continued until donor cycle day four. The 17B-estradiol dose was increased to 6 mg daily from cycle days five to eight. At this point, 8 mg (2 mg q.i.d.) of 17B-estradiol was administered daily until the donor received hCG, which was considered cycle day 14. The recipient then was instructed to receive 50 mg of intramuscular (IM) progesterone and to reduce the dose of 17B-estradiol to 2 mg twice daily. The luteal phase was maintained with 100 mg of progesterone IM and 4 mg of 17B-estradiol daily. An endometrial biopsy was performed during an artificial cycle and demonstrated normal endometrium on cycle day 25.

In Vitro Fertilization and Embryo Transfer (IVF-ET)

Transvaginal oocyte retrieval was performed 36 hours after the donor received hCG. Each oocyte was inseminated with 50,000 to 150,000 sperm four to six hours after retrieval. Embryo transfer to the recipient was performed when the embryos reached the four to eight cell stage approximately 48 hours after retrieval. Luteal phase support was maintained with 100 mg of progesterone and 4 mg of 17-beta-estradiol daily until a pregnancy test was positive. Twelve days after transfer a pregnancy test

was drawn. At three to four weeks' gestation an ultrasound was used to verify location and size of the gestational sacs. Pregnancy was confirmed by ultrasound verification and increasing levels of hCG. Estradiol and progesterone supplementation was continued until 10 weeks gestation.

Results

The donor and the recipient were synchronized on three cycles before a pregnancy was achieved. In the first cycle, four embryos were transferred and a single sac with a fetal heart motion was detected at 28 days after transfer. Seven days later, heart motion ceased and the patient required a dilation and evacuation for fetal demise. A second cycle failed to achieve implantation after transfer of six embryos. On the third cycle, eight embryos were transferred (Table 1). Four gestational sacs with fetal heart motion were detected on follow up ultrasound examinations.

Selected reduction from quadruplets to twins was decided by the couple, which was

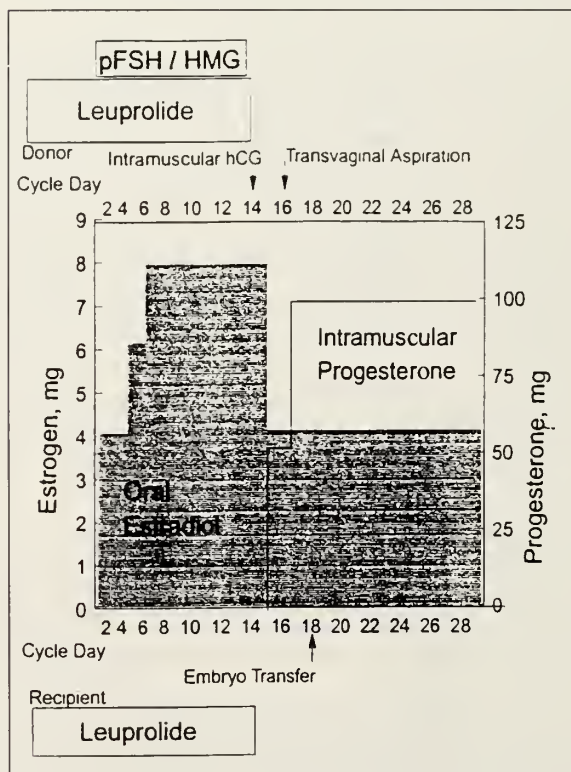


Figure 1. Stimulation protocol for the ovum donor and recipient

<u>Cycle, #</u>	<u>Oocytes, #</u>	<u>Fertilized, #</u>	<u>Cell Stage, #</u>	<u>Embryos Transferred</u>
1	5	4	3 - 4 cell	4
2	18	13	8 cell	6
3	22	15	4 - 8 cell	8

Table 1. In vitro fertilization results

performed by injection within the fetal thorax of potassium chloride. This procedure occurred without incident and the remaining twins were unaffected. The mother or recipient's prenatal course was uneventful and carried to 37 weeks' gestation. She underwent an elective caesarean section and delivered two male infants weighing 2930 grams and 2775 grams. Both went to the newborn nursery with the mother. The mother and both infants were discharged from the hospital three days after delivery.

Discussion

When dealing with menopausal patients, infertility can be secondary to oocyte number or quality and uterine factors. In patients utilizing their own gametes for standard IVF a significant reduction in embryo quality and uterine receptivity has been noted in women over the age of 40 compared to those who are younger.⁸ In treating infertile women older than 40 with standard IVF procedures 7.2 deliveries per 100 retrievals have been reported.⁹ Utilizing younger donor oocytes has significantly improved these statistics. One study illustrated a 40 percent clinical pregnancy rate in this population using oocytes from younger donors. These patients underwent ovum donation after a failed self-gamete cycle. This supports the importance of oocyte quality to IVF success in patients of advanced reproductive age.⁷ The endometrium of the recipient requires stimulation by exogenous gonadal hormones to create a histologically normal endometrium. This is accomplished with 17B-estradiol and progesterone. The endometrium of this artificial cycle is indistinguishable histologically from normal endometrium. This is documented with an

endometrial biopsy.

Careful screening is required for all couples with age-related infertility who choose an oocyte donor program as an option for fertility. Assisted reproductive tech-

niques produce a high percentage of multiple gestations. This increases the incidence of preterm labor, uterine atony, intrauterine growth retardation, and low-birth-weight infants. The most significant prenatal complications, in women over the age of 35, are chronic hypertension, gestational diabetes, and preterm labor.¹⁰ Due to age alone, infants born to mothers between the ages of 40 and 49 have an increased mortality. These patients are at risk for low-birth-weight infants, less than 2500 grams.¹¹ The problems which may arise neonatally can be minimized with appropriate pediatric services and compliant prenatal care.

This case report illustrates an option for patients with age-related infertility to achieve pregnancy. Using standard IVF protocols the pregnancy rates are notably decreased in this population. Using donor oocytes increases IVF success and may decrease the incidence of aneuploidy in recipients of advanced maternal age. Increasing the success rate per cycle and providing optimal obstetrical care can improve the quality of life for the aging infertile population.

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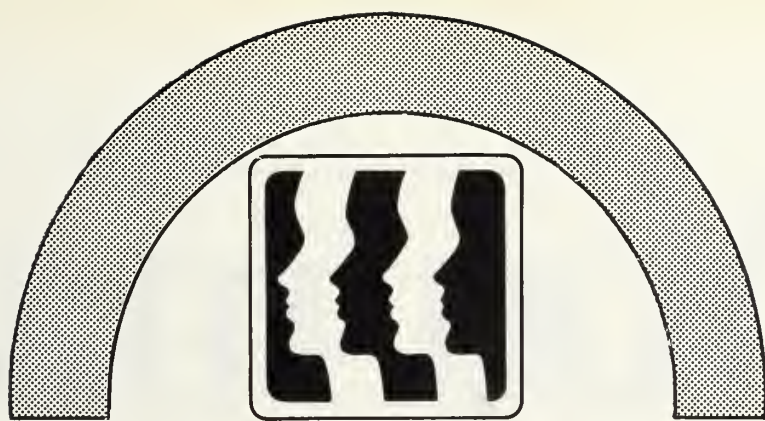
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Low-Dose Gonadotrophin Stimulation for Luteal Phase Defects — Does Absence of LH Help Pregnancy Rates?

Jerome H. Check MD

Brief Summary

Based on data suggesting that higher serum LH levels during the follicular phase may decrease subsequent pregnancy rates and increase spontaneous abortion rates, the study presented herein was designed to compare the pregnancy and abortion rates in patients treated with gonadotrophin preparations with and without LH content. Infertile patients with luteal phase defects related to releasing eggs prior to complete follicular maturation were randomized into two treatment arcs: ultra-low-dose (75IU) human menopausal gonadotrophin (hMG) versus pure FSH. However, they were given the right to refuse the recommended treatment and use the other one if they preferred. Pregnancy and spontaneous abortion rates were determined for first cycle of therapy. The pregnancy rates for hMG versus pure FSH was 22.7 percent and 20.3 percent, respectively. The spontaneous abortion rates were also similar (8 percent and 9.1 percent). There were no multiple births resulting from these 36 pregnancies. Ovarian hyperstimulation syndrome was not observed in any of the 164 stimulation cycles. These data demonstrate that the use of an ultra-low-dose gonadotrophin stimulation regimen is an

effective method of correcting infertility related to luteal phase defects related to follicular maturation defects since the overall pregnancy rate per first cycle of treatment was 22 percent despite a minimum of 10 months of infertility duration. Furthermore, an ultra-low-dose gonadotrophin regimen is safe for treating luteal phase defects in that there was no ovarian hyperstimulation or multiple births demonstrated. These results also show no advantage of choosing a preparation devoid of LH, thus giving the patient the opportunity to purchase the least expensive medication that is available.

Introduction

A previous study found that treatment with the combination of follicle-maturing drugs (either clomiphene citrate [CC] or gonadotrophins) and progesterone (P) support in the luteal phase resulted in a higher viable pregnancy rate (PR) than did either of these two therapies alone in patients with luteal phase defects who did not attain a mature follicle.¹ The gonadotrophin preparation used in that study was human menopausal gonadotrophins (hMG) exclusively and the dosage used was conventional (mostly 150 IU hMG daily).¹

The use of an ultra-low-dose gonadotrophin regimen was found to be safer and more effective than conventional use of hMG in patients with polycystic ovarian syndrome.² The gonadotrophin preparation used for that

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study was purified follicle stimulating hormone (pFSH).² The study presented herein compares the efficacy of low-dose hMG vs. pFSH for infertile women with luteal phase defects whose oocyte released prior to attaining a serum estradiol (E_2) of 200 pg/mL.

Materials and Methods

All patients diagnosed with luteal phase defects (by demonstrating a late luteal phase endometrial biopsy more than two days out-of-phase in two consecutive cycles) from October 1991 to December 1992 who did not attain a serum $E_2 \geq 200$ pg/mL prior to oocyte release (demonstrated by pelvic sonography) were given ultra-low dose hMG or pFSH. The initial option of hMG or pFSH was on a randomized basis; however, they were advised that we believed that at least with conventional dosages of pFSH there may be an increased risk of ovarian hyperstimulation syndrome.³ If the patient refused pFSH, she was given ultra-low-dose hMG and still included in the study. The study would be concluded when there were at least 50 patients in each group. Patients were required to have a minimum of 10 months of infertility duration (unless they were being seen for recurrent spontaneous abortion [SAB]), at least one patent fallopian tube by hysterosalpingography or laparoscopy, and a male partner with at least an 8×10^6 /mL motile density, to be included in the study. Furthermore, a mid-luteal phase serum P was required to be > 5 ng/mL.

The hMG and pFSH were started with one ampule (75 IU FSH and luteinizing hormone [LH]; 75 IU pFSH) daily from day five and continued at this dosage for at least seven days.

If the E_2 levels were progressively rising, the one ampule dosage was maintained; however, an inadequate response would prompt an increase in dosage to 1.5 ampules/day. When at least one follicle attained an average diameter of 18-24 mm with a serum E_2 of a minimum of 200pg/mL for one follicle or 150 IU per each follicle attaining an 18 mm diameter, 10,000 U human chorionic gonadotrophin (hCG) was given intramuscularly (IM). Following oocyte release, the luteal phase was supplemented by oral micronized P capsules 50 mg 4x/day.

Patients were monitored by sera E_2 and sonography at mid-cycle. Only those patients demonstrating a gestational sac on ultrasound were considered pregnant. Only first cycles of gonadotrophin therapy were included.

Results

Ninety percent of the patients had been treated with one to four cycles previously with CC and had failed to conceive. One hundred and ten patients received ultra-low-dose hMG vs. 54 taking ultra-low dose pFSH.

Pregnancies were achieved by 25 patients (22.7 percent) treated with hMG vs. 11 (20.3 percent) with pFSH ($p=NS$, chi-square analysis). Spontaneous abortion occurred in two of 25 (8 percent) pregnant patients treated with hMG and in one of 11 (9.1 percent) pregnant patients treated with pFSH.

The risk for multiple births with gonadotrophin therapy has been estimated at approximately 11 to 42 percent per treatment cycle. All 36 pregnancies in this study were singletons. There were no cycles with clinical ovarian hyperstimulation syndrome with either gonadotrophin preparation.

	hMG group (n=110)	FSH group (n=54)
Race		
White	62 (56.4%)	31 (57.4%)
Black	1 (0.9%)	1 (1.8%)
Other	2 (1.8%)	0 (0.0%)
Not available	45 (40.9%)	22 (40.7%)
Age (years)		
Mean (SD)	33.1 (4.6)	31.3 (3.7)
Insurance type		
HMO	25 (22.7%)	15 (27.8%)
Private	79 (71.8%)	37 (68.5%)
Unknown	6 (5.5%)	2 (3.7%)

$p > .05$, all comparisons (no significant differences)

Table 1. Demographic profile

	hMG (n=110)	FSH (n=54)
Length of infertility (years)		
Mean (SD)	1.8 (1.2)	1.9 (1.2)
Type		
Primary	42 (38.2%)	26 (48.1%)
Secondary	66 (60.0%)	27 (50.0%)
Recurrent abortions	2 (1.8%)	1 (1.8%)

Table 2. Infertility history

Hormone levels on initial consultation	hMG	Normal range	FSH
Androgens			
Androstenedione	164.5±64.8	10-299ng/dL	162.0±61.9
Dehydroepiandrosterone sulfate (ug/dL)	206±98.7	25-410ug/dL	206±101.8
Testosterone (ng/dL)	34.4±23.6	20-80ng/dL	33.0±17.0
Free testosterone (pg/mL)	2.5±2.5	0.7-3.6pg/mL	2.7±2.3
Prolactin (ng/mL)	9.4±7.2	5.1-22.6ng/mL	8.8±3.6
FSH (initial consult) (mIU/mL)	12.7±7.4	13-15.0mIU/mL	15.1±13.5
LH (mIU/mL)	16.1±13.9	1-31mIU/mL	17.7±13.7
Day 2 or 3 hormonal levels			
FSH	12.0±2.9		13.8±5.4
LH	12.1±4.8		9.7±5.3

* Data presented as mean ± SD (n); p>.05 for all sera levels measured (no significant differences)

Table 3. Baseline endocrine profile*

The demographic profile of the hMG vs. pFSH group is seen in Table 1. There were no differences seen in race, age or insurance type. The infertility history of the two groups is presented in Table 2; no statistical differences were noted.

The sera hormone levels obtained on initial consultation are seen in Table 3; no differences in androgen levels or prolactin were noted. Furthermore, no differences were seen in day two or three sera LH and FSH levels.

Furthermore, no differences were noted between the groups in number of mature follicles >15 mm or >17 mm, incidence of luteinized unruptured follicle syndrome, or sera E₂, P or LH at the time of hCG injection as seen in Table 4.

Finally, no differences were noted in the amount of medication needed to induce follicular maturation (Table 5).

Discussion

There have been several manuscripts demonstrating the safety and efficacy of ultra-low-dose pFSH therapy for anovulatory patients with polycystic ovarian syndrome.^{2,4} The study presented herein is unique because it evaluated ultra-low-dose gonadotrophin therapy in patients with luteal phase defects not attaining mature follicles. In contrast to a previous study where pFSH was found more risky than hMG for developing ovarian hyperstimulation syndrome following conventional dosages,³ no

	hMG	FSH
Mature follicles		
> 15 mm (mean)	1.8±1.1	1.9±1.3
> 17 mm (mean)	1.4±1.0	1.5±1.3
Sonographic confirmation of release		
Yes	91 (82.7%)	39 (72.2%)
No	9 (8.2%)	8 (14.8%)
Inconclusive	10 (9.1%)	5 (9.2%)
Luteinized unruptured follicle	0 (0.0%)	2 (3.7%)
Sera hormone levels at peak follicular development		
E ₂ (pg/mL)	364.5±183.1	409.8±253.4
P (ng/mL)	.6±.4	.6±.5
LH (mIU/mL)	27.8±32.2	31.4±25.1

* Data presented as mean ± standard deviation (sample size); p>.05 comparing groups on each parameter

Table 4. Mid-cycle follicular dynamics and sera hormone levels

ovarian hyperstimulation syndrome was found with either ultra-low-dose gonadotrophin regimen.

The PRs with both ultra-low-dose regimens were certainly comparable to higher dose conventional regimens, with greater safety to the patient. Multiple births would normally be expected with conventional hMG therapy in 20 percent of the cases and even a low-dose (but not ultra-low-dose) regimen was found to be associated with a frequency of 15 percent.⁵ There were no multiple births in 36 pregnancies in this study as compared to the expected five to seven with higher dose gonadotrophin regimens.

There has been another manuscript randomly comparing ultra-low-dose pFSH vs. hMG with similar conclusions, i.e., that both drugs are equally safe and effective.⁴

	hMG	FSH
Total ampules administered		
Mean ± SD	9.3±4.2	10.8±5.0
Total days on medication		
Mean ± SD	8.5±2.9	9.6±3.4
Number of patients requiring		
1 amp dosage only	74 (67.3%)	32 (58.2%)
1 amp and 1.5 amps	22 (20.0%)	16 (29.6%)
1, 1.5, and 2	4 (3.6%)	3 (5.6%)
1 and 2 amps	9 (8.2%)	2 (3.7%)
Not available	1 (.9%)	1 (1.8%)

* p>.05 all on tests (no significant differences)

Table 5. Comparison of ovulation induction therapy

However, the patients used in Sagle et al.'s study all had polycystic ovarian syndrome.⁴ The study presented herein, to our knowledge, is unique in the world's literature in randomly comparing these two gonadotrophin preparations in patients with luteal phase defects associated with immature follicles.

There have been some studies suggesting that higher levels of serum LH in the follicular phase reduce PRs and increase SAB rates.^{6,7} Based on these studies, some clinicians have hypothesized that the LH content of gonadotrophin preparation, e.g., hMG, may have negative effects on pregnancy outcome.

Daya et al. evaluated fertilization rates and PRs with in vitro fertilization using a short flare-up controlled ovarian hyperstimulation regimen and found a significantly higher fertilization rate and a trend to higher PRs when the gonadotrophin regimen used was pFSH compared to hMG.¹² They attributed the decreased fertilization and PRs with hMG to the possible adverse effects of high LH during the follicular phase.

However, we published data involving the longer use of luteal phase leuprolide acetate followed by gonadotrophin therapy (pFSH vs. hMG) and found no differences in fertilization or PRs though there was a trend toward higher cancellation rates with pFSH.⁹ Furthermore, we have found that women with luteal phase defects do not have a lower PR or higher SAB rate in women with high serum LH levels during the follicular phase;¹⁰ this study suggested that the adverse effects of high serum LH may be overcome by the use of supplemental P in the luteal phase. In fact, there have been studies demonstrating a reduction in SABs with the use of supplemental P in the luteal phase when women have been stimulated with either CC or hMG.^{15,16} Though the spontaneous abortion rates were <10 percent with either hMG or pFSH in the study presented herein, both groups did receive P in the luteal phase. Thus, the possibility does exist that the use of gonadotrophin preparations containing LH could be associated with lower PRs or higher spontaneous abortion rates when P is not

supplemented in the luteal phase when stimulating with pFSH.

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SPECIAL REPORT

Medical Society of Delaware Insurance Services, Inc. Report to the Stockholders

Logistically it was necessary to submit the 1995 MSDIS Annual Report by mid-October 1995. This report was published in the Journal as part of the Proceedings of the House of Delegates (*Del Med Jrl*, Feb 96, Vol 68, No 2, pp 124-125). This annual report discussed in some detail the joint venture arrangements with the Professional Liability Division of the Harry David Zutz Insurance Agency and Risk Transfer Administrators; RTA for health insurance and related products and Zutz for professional liability insurance and all other insurance products that would be needed and of interest to physicians, their families and office staffs. This report emphasized the growth of MSDIS in 1995 and the growth anticipated in the future stressing the need for *all* Delaware physicians to become participants by purchasing their insurance from MSDIS/PLI-Zutz and MSDIS/Health Select. Since the stockholders of MSDIS are the members of MSD and by virtue of their corporate charter, the House of Delegates and the Board of Trustees provide oversight of MSDIS and the MSDIS Board of Directors, it seems appropriate to provide this up to date Special Report at this time rather than a year from now.

The final financial reports and statistics were developed at the end of the MSDIS fiscal year (December 31, 1995). With this information in hand we can now provide more details of the very positive results of 1995 to the stockholders and to again stress the continuing need for *all* Delaware physicians to become participants with the Medical Society's insurance subsidiary.

The January issue of MSDNews pre-empted this article's primary finding for 1995, by promptly reporting the record MSDIS dividend to the Society of \$160,000. In addition, as the auditors closed the books for 1995 some other important statistics became available. For example, there was a net gain of 60 new medical malpractice insureds that now provide MSDIS/PLI-Zutz with a most significant percent of the available market share.

Health Select, which is the melding of the Medical Society's Principal Health contract with the individual sales of RTA, has grown well over 100 percent with over 1,000 insureds currently on the books. Health Select is unique with its ability to provide the right coverage for each individual practice by virtue of its depth of options among 25 different health insurance companies to choose from, to tailor-make the exact program the physician needs for his/her family and employees.

In addition to the medical liability insurance provided by MSDIS/PLI-Zutz, 13 other insurance products have been purchased by a number of Delaware physicians and facilities with which they are affiliated. In 1994, MSDIS only offered office packages, workman's compensation and disability insurance. The total number of policies at that time was 86. At the end of 1995, well over 300 policies had been issued not only for the same products as listed in 1994, but for personal and commercial autos, home owners, fire, inland marine, directors and officers, and other insurance products.

By the time this is published, another service to all the members of the Society as well

as to all our MSDIS insureds will have been in place for several weeks. This service is the offering of Cafeteria Plans; the use of pre-tax dollars by the physicians' practice and employees, provided by MSDIS/Health Select through a very low cost program developed with Mayer, Hoffman and McCann, CPAs. This is a Society benefit from which MSDIS, having worked out all the details, will receive no remuneration. Following this, next on the agenda for the MSDIS Board of Directors, will be consideration of pension plans, including 401(k) plans and other financial planning options. Although mentioned above, the ability of the Society and MSDIS to provide such comprehensive services is by virtue of Delaware physician support. That is why it is important for *all* Delaware physicians to become participants.

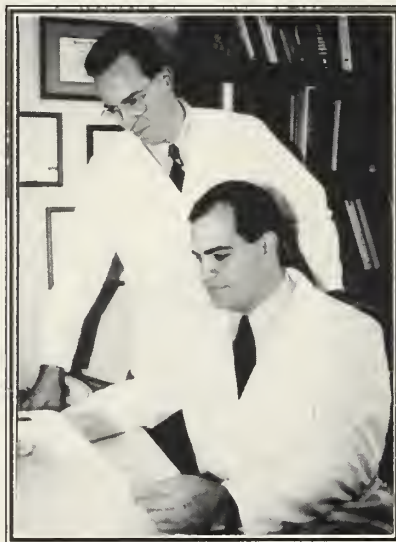
For the last three years, it has truly been my privilege to serve the Medical Society in the role of MSDIS' president. In these three years, all the basic goals set out to be accomplished have been achieved; namely: establishment of impeccable creditability among the physicians in the State; creation of stability in the organization, functioning and democratization of the agency; and enhancing the profitability of the agency to the Society, the stockholders. This is all due to the dedication of the MSDIS Board of Directors and our two joint venture partners.

In addition, I appreciate the honor bestowed upon me by the House of Delegates making me *Director Emeritus* of MSDIS and by the Board of Directors permitting me to become a consultant to PLI-Zutz. This means that in the foreseeable future I will continue to be involved with the Society and MSDIS. However, what must be done now rests with you, the stockholders, Delaware physicians. By purchasing your insurance from MSDIS you will permit both MSDIS and the Society to continue to offer new and enhanced services to you.

William H. Duncan MD
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Leonard Philip Lang MD, FACP
February 4, 1913 — November 16, 1995

E. Wayne Martz MD

On Thursday, November 16, 1995 Leonard Lang quietly slept away at his home on River Road in Wilmington, ending a career of 56 years as a physician, educator, administrator and friend to thousands. I was surprised to see his obituary in the *News Journal* headlined as being "renowned in Delaware for his TB expertise." It had not occurred to me that this was the way he was publicly perceived. He was so much more than that to all those who knew him. I am not even going to call this an obituary but rather a series of remembrances because he lives on in different ways in so many hearts and minds. Each of us perceived him differently.

Everyone has multiple audiences. He was one person to his wife Wilma, another to his children, yet another to his professional colleagues. It is the impact of our personalities and beliefs and the way we live our lives that survives, and Leonard had impact. Modest in his lifestyle, almost scornful of money, yet strong in his convictions and dedicated to integrity, he was a fighter from his boxing days at CMTC camp and at Penn State until his death at 82.

When Leonard and I first met in 1969 or 70, we had some pretty vigorous discussions, to say the least. Most of these discussions concerned the direction that the evolution of the Medical Center of Delaware (then called Wilmington Medical Center) should take. He was sharply critical of the persons leading the charge, and

when it was suggested he become a candidate for full-time director of the Department of Medicine, he greeted it with disbelief. Because of his opposition, he did not believe he would be taken as a serious candidate. But the search committee was headed by John Egan MD, an extremely fair minded man with an uncanny ability to get beyond superficialities and evaluate true worth. John's committee selected Leonard unanimously from a long list of candidates. When he became one of those making the hard decisions and setting the direction, and saw his ideas implemented, with responsibility for the outcome, his "anti" stance disappeared. He became a team player, never afraid to speak up — nobody was his boss — but not an obstructionist either.

Leonard was a proud man, and I never knew him to say "I'm sorry" about anything; not for lack of contrition but because the past is not worth wasting time on. Go on to the next decision. He worked hard, stud-

ied hard, had an excellent retentive mind and a generous portion of good sense in his decisions, medical and administrative. He was one of the very first to take the recertification examinations of the American Board of Internal Medicine, 40 years after medical school.

It is funny how little things affect relationships. He once watched me making rounds with residents, and noting that I knocked on patients' doors before entering,



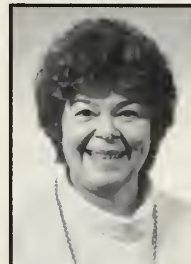
concluded that I "couldn't be all bad." That's the way he was. First of all a gentleman, considerate and thoughtful of patients, and second, no compliments for doing what you should do, but you knew when you met with his approval. I am sure that generations of doctors he taught will knock on hospital doors before entering.

Most of all I remember his caring and concern for his residents, insisting on high standards of medicine and behavior, but kind and patient in his teaching. I think that more than anything else this was responsible for the success of his residency program. Many hospitals have good programs, good doctors, interesting and challenging patients, but also many take advantage of the residents. Leonard cared for them like his own children, and that enabled him to attract numbers of superior residents, who then made his and the program's reputation.

He believed in taking life as it comes and doing the best you can with what you have. He was still seeing patients in clinic a couple weeks before he died. When I visited him at home the week before he died, he said, recognizing the metastatic disease that he had, "I didn't ask to be dealt this hand, but I'll play it the best I can." He went to bed four days later; got up for one day to participate in a surprise family get together, then back to bed, and within 24 to 36 hours into a coma from which he did not awaken. In charge to the end. That's how I remember him.

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Screening Concerns

A Response to Dr. James Gill's Letter to the Editor

Robert Frelick MD

Dr. Gill's article¹ in the January issue of the *Delaware Medical Journal* criticized a checklist for cancer screening proposed by Dr. Chodos in the September issue of the *Journal*.² Dr. Gill was concerned because several of the proposed screens were not "evidence based." He cited as an example that the finding of early prostate cancer is more likely to be detrimental than helpful. Yet, Dr. Gill recognized the importance of checklists to encourage earlier detection of cancer. Since the cure rate is very high for most properly treated early-staged cancers, finding early stages of cancer is an important way to reduce the death rate from cancer in Delaware. Although the *incidence* of the five most common cancers is somewhat elevated, high *death rates*, especially in minority populations, are Delaware's major problem.³ Early detection is essential for the populations most likely to die from cancer. The importance of such early detection was emphasized in a recent study of a number of U.S. communities which showed that the increased cancer death rate in minorities appeared to be chiefly related to delayed diagnosis and treatment.⁴

Dr. Gill did not clarify the basis upon which the U.S. Preventive Services Task Force⁵ based its recommendations. The most important, as expected, were randomized clinical trials with the least credibility given to descriptive and epidemiologic studies. The approved guidelines were based on randomized controlled

studies of *individual* screening procedures modified by the detrimental impacts of the screen including its costs. Many cost-effective studies are based on mathematical models which are not necessarily "evidence based." The potential years of life saved are usually noted as part of the benefits vs. costs.⁶ Most cost effective studies, especially those of the widely quoted Dr. Eddy,⁷ use assumptions which can be questioned.

Should the risk of screening include the cost? In any case, shouldn't candidates for screening be told of their options, including the costs, even if insurance or HMOs may not pay for their choice?

It is surprising that Dr. Gill, a family practitioner, did not point out that most primary care physicians can provide many screening studies during a single office visit. Such screening studies have to be more cost effective when grouped together, compared to each screen needing a separate office visit. A few studies, such as mammography, usually require separate visits. However, it is feasible to check the skin, oropharynx, feel the neck, measure the blood pressure, take blood for a cholesterol and blood sugar test, examine the breasts, the size of the liver and peripheral nodes, do a pelvic exam with a pap smear, and include a rectal with a stool test for blood in a single brief visit.

Since PSA came into common usage in 1991 there has been a significant increase in the number of cases of early prostate cancer found, but it is too soon to know if treating those men will result in a reduction in prostate cancer deaths, although that is a reasonable conclusion. Just because a screen has not been proven to be of value does not mean that a

screen is no good. Frequently there have been no randomized studies to demonstrate a screen is or is not of value as is true in the above situation. Often such studies would not be ethical. Since the value of screens is usually based on whether the screen reduces the death rate, it seems appropriate that the detrimental effects should similarly be based on whether the screen has caused any deaths, and that appears to be rare. Avoiding the unhappy results of advanced prostate cancer may be worth some morbidity, such as the loss of erectile power and/or incontinence, even in those whose length of life may be shortened by deaths from other causes. The patient should be allowed to decide if he wants to be screened and not have that opportunity eliminated because of the U.S. Preventive Services Task Force definition of an evidence-based screen.

C.J. McDonald recently pointed out⁸ that it is impossible to have randomized clinical trials upon which to base all of the clinical decisions which physicians have to make. Furthermore, randomized controlled studies usually require careful selection of the subjects who obviously are not randomly chosen from the general population. The choice of populations probably explains why randomized studies on the same subject often do not agree. Many epidemiological studies may be more representative of the real world than randomized controlled studies, and thus provide a better evidence for screening than some randomized controlled studies.

Even adding epidemiological to randomized controlled studies will not provide enough information upon which evidence-based medical decisions and recommendations can be made under all circumstances. Until more data are available, physicians and their patients often have to intuitively decide which cancer screen to use. Clinical situations as well as race, educational status, economic resources, age, and genetic backgrounds should influence the recommendations for an individual at risk for developing cancer.

The recommendations of all major authorities are presented in the screening recommendations published last year by the U.S. Public Health Service in the "Clinician's Handbook of Preventive Services"⁹ as part of its "Putting

Prevention into Practice" program. For example, the American Cancer Society and the American College of Radiology provide reasonable scientific evidence to back their point of view that mammograms should be done at different frequencies than those recommended by the NCI Staff (not their advisory body, the National Cancer Advisory Board) and the Preventive Task Force.

The definition of what is an "evidence-based" screen is unfortunately not as clear cut as Dr. Gill implies. Yet, hopefully all can agree to the need to promote early detection as part of primary care practice, preferably as office case finding and not as large group screening efforts which pose additional problems for recruitment and for follow up. Admittedly, the suggestion for office case findings is empiric without studies to show that office case finding saves lives.

Dr. Gill's endorsement of screening checklists is encouraging. It is too bad that he did not also promote the use of tickler files in physicians' offices to remind patients when the next "screen" is due, especially screens as specific as possible for each individual patient. Dentists and veterinarians usually do a much better job of reminding patients to return for check ups than physicians. It is too bad that more physicians' office staffs do not understand the value of a tickler file in addition to an appointment book for reminder notices to promote secondary preventive measures for not only cancer but many other chronic diseases.

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More On Cancer Screening

Joel Chodos MD FACP

In reading Dr. James Gill's article "Is Cancer Screening Always Good for Patients?"¹, I was left with the impression that the thrust of my article "A Practical Office Flow Sheet for Cancer Screening in Adults"² was missed. In the text of the article accompanying the flowsheet I clearly express that the scientific evidence supporting various screening tests varies from strong to unproven and that screening guidelines are controversial. I specifically cited references regarding the evidence behind the major tests listed, including pointing out that prostate cancer screening was more popular than proven at present. The flow sheet was not published in isolation but in the context of the important caveats concisely but clearly discussed in the article text accompanying it, and I believe the emphasis was clearly made that we need to analyze screening recommendations carefully and critically. If the average reader read Dr. Gill's article without reading mine, he would be misled into believing that I was advocating screening far more liberally and less cautiously than I do.

The inclusion of the PSA test in the sheet was made after deliberation and careful

thought recognizing that it is controversial, but also recognizing that it is frequently being used by many primary physicians, asked for by patients and endorsed by the American Cancer Society and American Urological Association. It is listed in the sheet as being "suggested over age 50" and a frequency was deliberately not

specified in order to make this item of the list "softer" than the rest. I personally am not a big fan of PSA testing for screening in asymptomatic individuals and recognize how it can lead to costly subsequent workups and surgery that in the long run might not benefit the patient and actually have a negative effect in some.

The real problem with prostate cancer screening is that we need a way of separating the indolent tumors that are best left alone from the aggressive tumors³ and so far we don't have such a screening technique although various approaches have been pursued.⁴ Screening efforts on prostate cancer occur in a backdrop of rising mortality statistics⁵ and so it is understandable why PSA has become a "hot" topic and one in which screening proponents are straining to do something positive, even though proof of efficacy is not present.

Of all the items on the screening sheet I prepared, basically only the PSA is controver-

"If the average reader read Dr. Gill's article without reading mine, he would be misled into believing that I was advocating screening far more liberally and less cautiously than I do."

Dr. Chodos is a gastroenterologist in practice in Wilmington. He is a volunteer board member of the American Cancer Society.

sial, the rest are not (with the possible exception of age at which to begin mammography screening).

A feature made prominent on the screening sheet, but that is overlooked by many in day to day clinical practice, is focusing on the family history and risk factors in helping decide whom to screen and helping the clinician decide how important a particular screening may be to a specific patient. The way the flow sheet is designed makes the family history stand out so it is not forgotten or buried in the chart.

Regarding the issue of Dr. Gill's suggestion of relying mostly on the US Preventative Service Task Force (USPSTF) guidelines, it is important to recognize that the USPSTF, while rigorous and noble in purpose, is a very conservative vehicle and slow to act: it still does not list a digital rectal exam among

recommended screening tests for older adults and did not endorse sigmoidoscopy until 1995.

I believe Dr. Gill's view and mine regarding screening are more similar than different and that the criticisms weighed against the screening sheet I designed were somewhat misdirected. We are on the same side of the fence.

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CORRESPONDENCE

A Special Letter to the Editor

The Medical Society continues to receive letters and hear praises of our own Dr. David Platt, a man who has indeed devoted his life to our community. He brings great credit to our profession, but he needs our help. I gave two school health talks for him last week but he needs more help. Please give him a call to volunteer to speak for the Speakers' Bureau or the School Health Talks, Contact Lauryn Harkness at the Medical Society of Delaware (302) 658-7596 or in Kent and Sussex Counties (800) 348-6800.

Dr. David Platt
Medical Society of Delaware
1925 Lovering Avenue
Wilmington, DE 19806

Dear Dr. Platt:

It is very good of the Medical Society of Delaware to provide health awareness talks to students in our schools.

Your January 18th presentation, "Hearing Damage from Loud Music" was very well received by our primary level students. You spoke about this topic in a simple, clear way so our special education students were able to further their understanding of how they can keep their bodies healthy. I think the children especially benefitted from interacting with a physician outside of a traditional office/hospital setting.

All of the primary team appreciate you giving your time and expertise to our students. Please also extend my thanks to Ms. Lauryn Harkness for doing a fine job of coordinating this presentation. We hope to have more student health presentations in the future.

Sincerely,

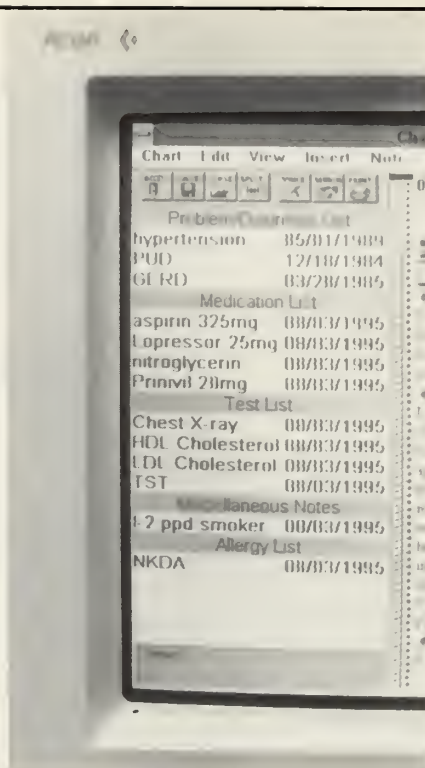
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AMA COMMITTEE REPORTS

AMA House of Delegates Meeting

Reference Committee C (Medical Education)

Reference Committee C approved language strengthening AMA policy with regard to the interaction and supervision of advanced practice nurses (APN) by physicians. This is a moot point in Delaware since the Medical Society of Delaware was effective in influencing State law in this area requiring a formal collaborative agreement between an APN and a physician. Furthermore, the diagnostic and prescriptive privileges of APNs with such certification are regulated by a Council of the Board of Medical Practice.

Another area of policy reviewed by this reference committee dealt with the issue of Board Certification and its impact on participation in managed care. One answer to the problems created by lack of Board Certification would be addressed by the issuing of Certificates of Completion of specialty training. This provision would in particular assist physicians having recently completed training who cannot sit for their boards prior to a period of clinical practice. In general, the activities of this committee sought to develop policy to reflect and communicate to managed care organizations the fact that Board Certification in and of itself does not reflect clinical quality and should not in and of itself reflect a reason for exclusion from managed care physician panels. The HOD did not, however, approve the concept that all specialty boards should create a one-time window of opportunity for non-Board Certified but physicians fully trained in their specialty to sit for the board examination.

The committee approved general guidelines for how hospital privileges should be

granted to physicians who have trained in specialties that do not generally receive such privileges. It is anticipated that the specific guidelines for granting such privileges will be developed by the appropriate organizations in the future.

A wide range of reports and resolutions related to specific changes in the physician work force were not adopted. Attempts to better understand the issues related to physician work force were supported through further study.

A variety of resolutions were adopted to insure that federally supported health insurance as well as other third party payers be required to continue the financial support of graduate medical education.

It has recently come to light that the National Resident Matching Program, although believed to favor medical students in the case of a tie, in fact, favors hospitals. As such a number of resolutions were adopted to correct this as well as to correct such misconception through adequate disclosure.

Stephen R. Permut MD

Reference Committee E (Scientific Affairs)

This committee adopted reports and resolutions supporting the following:

1. The need for mothers delivering infants while incarcerated to have ample opportunity to bond with their infants.
2. The use of estrogen and calcium for postmenopausal women.
3. The use of folic acid through fortification of cereals in an attempt to prevent neural tube defects in newborns. They also

encouraged the FDA to further study the effect of folic acid on cardiovascular disease.

4. Other public health initiatives were also supported including breast carcinoma screening, collection of umbilical cord blood for stem cell transplantation donation, education regarding antibiotic usage and resistance, and colon and rectal cancer screening.

Stephen R. Permut MD

Summary of Reference Committee H

The proceedings of this committee centered on issues such as medical bylaws as contracts; reporting of information in the National Practitioner Data Bank; practice limitations; publishing of reimbursement methodologies; "observation care"; peer review; and the documentation of the validity of the medical record. The House of Delegates adopted the following:

1) That the AMA develop model state legislation providing that hospital medical staff bylaws are a contract between the organized medical staff and the hospital; that the AMA not seek the introduction of federal legislation mandating that medical staff bylaws be viewed as a contract; and that the AMA Commissioners to the Joint Commission on Accreditation of Healthcare Organizations seek incorporation of the statement in the Accreditation Manual for Hospitals: "The Medical Staff Bylaws, as adopted or amended by the medical staff and approved by the governing body, create a system of mutual rights and responsibilities between members of the medical staff and the hospital to which the medical staff and the hospital intend to be contractually bound."

2) That the AMA seats on the JCAHO Board of Commissioners be filled by current members of the Board of Trustees and that the Board of Trustees develop a method for including non-trustees to fill some of those seats. Such a plan is to be reported to the House of Delegates at the 1996 Annual Meeting.

3) Referral to the Board of Trustees for report to the House of Delegates at the 1996 Annual

Meeting, Resolution 810 which called for AMA adoption of the following:

a) Copies of minutes of all medical staff committees, except minutes concerning peer review or corrective action information, should be made available to all medical staff members.

b) All policies which emanate from committee meetings where peer review issues are discussed and which affect medical staff members must be approved by the appropriate department and/or the medical staff executive committee and communicated to the medical staff.

4) That the AMA review the appropriateness of the National Practitioner Data Bank including malpractice history of physicians in training when the actions result from activity performed within the parameters of the physician's supervised training program; that policy 355.987, calling for the dissolution of the National Practitioner Data Bank, be reaffirmed; and that the Board of Trustees report back to the House of Delegates at the 1996 Annual Meeting on its progress in implementing policy 355.987.

5) That the AMA urge all third party payors and self-insured plans to publish their payment policies, rules, and fee schedules; that the AMA pursue all appropriate means to make publication of payment policies and fee schedules a requirement for third party payors and self-insured plans; that the AMA work with the National Association of Insurance Commissioners, develop model state legislation, as well as developing national legislation affecting those entities that are subject to ERISA rules; and that the Board of Trustees explore the possibility of adding payor publication of payment policies and fee schedules to the Patient Protection Act.

6) Referral of Resolution 806 to the Board of Trustees with a report to the House of Delegates at the 1996 Annual Meeting. The resolution called for the AMA to request that the Joint Commission on Accreditation of

Healthcare Organizations and other hospital accrediting authorities accept the physician's signature on the cover page of the medical record and the discharge summary as attesting to the validity of the contents of the entire medical record.

7) That in accordance with AMA revised policy 155.978 our AMA actively begin the process of identifying and seeking the correction of taxonomic and methodological deficiencies in data on health care spending in the United States for comparison to similar expenditures from other industrialized countries and that the Board of Trustees present a status report at the 1996 Annual Meeting.

8) That the AMA continue to work with representatives of the health insurance industry and the hospital industry to develop a consistent definition of a hospital stay; the AMA definition of a hospital day be advocated with payers as the most equitable definition; that policy 240.987, Defining Hospital Inpatient and Outpatient Stays be reaffirmed. (Some hospitals count the number of patients at the time of the census and do not report fractions of a day.)

9) That the CPT Editorial Panel continue to evaluate the appropriateness of identifying (either by addition of separate codes, modifiers or other appropriate method) services provided by independently practicing non-physician providers.

10) That the AMA seek, through all appropriate means, to require that all insurance carriers and managed care organizations use the AMA's CPT coding system; as updated yearly, as the exclusive national coding system; that payors and managed care organizations be required to implement their yearly update on a common date, preferably January 1 of each year.

11) That the AMA Commissioners to the JCAHO continue to investigate the problem of documentation of continuing medical education and seek appropriate solutions, and include information on the disposition of the matter in its regular report to the House of

Delegates at the 1996 Annual Meeting.

12) That the AMA support model hospital medical staff bylaws requiring the same due process in limiting professional practice for economic or contractual reasons as is followed for quality reasons; and that the AMA clarify that practice limitations based on economic or contractual reasons are not reportable to the National Practitioner Data Bank.

13) That the AMA establish policy on "observation care" and develop model legislation to ensure that:

- a) After initial approval of inpatient admission by insurers, there should be no retrospective reassignment to "observation care" status by insurers unless the original information given to insurers is incorrect.
- b) Insurers should provide 60 days prior notice to providers of changes to "observation care" criteria of the application of those criteria with opportunity of comment. There should be no implementation of criteria or changes without first following these protocols.
- c) Insurers' "observation care" policies should include an administrative appeal process to deal with all utilization and technical denials within a 60 day time frame for final resolution. An expedited appeal process should be available for patients in the admission process, allowing for a decision within 24 hours.
- d) Insurers and HMOs should provide clearly written educational materials on "observation care" to subscribers highlighting differences between inpatient and "observation care" benefits and patient appeal procedures.

14) That the AMA work with the Federation of State Medical Boards to adopt a policy to support state legislative efforts to protect the integrity and effectiveness of the peer review process by prohibiting managed care companies from automatically terminating providers who have been sanctioned by state medical boards or by information being provided by the National Practitioner Data Bank without providing due process to the provider.

15) That the following guidelines for physicians' responsibilities be adopted and disseminated to physicians and interested organizations:

1. Physicians are responsible to their patients for delivery of care in all subacute settings, 24 hours a day, 7 days a week.
2. Patients who might benefit from subacute care should be admitted to and discharged under the orders of the physician who is responsible for the continuous medical management needed to meet the patient's needs and safety and maintaining quality of care.
3. Physicians are responsible for coordinating care for their patients with other physicians including medical directors, primary care physicians, and appropriate specialists, to optimize the quality of care in subacute settings.
4. Physicians are responsible for supervision and coordination of the medical care for their patients and providing leadership for all other health care providers in subacute care.
5. Physicians should guide procedures for their patients performed within integrated practices and direct other health care providers, consistent with federal and state regulations.
6. Physicians are responsible for:
 - a. Fulfilling their roles and identifying the medical skills needed to deliver care in subacute facilities and for creating and developing continuing medical education to meet the special needs of patients in subacute care.
 - b. Identifying and appropriately utilizing subacute care facilities in their communities.
 - c. Oversight of physician credentialing in subacute settings
 - d. Promoting medical staff organization and by-laws that may be needed to support peer evaluations.
 - e. Planning care of their patients with acute and chronic conditions in subacute care, as well as pursuing efforts to restore and maintain functions for quality of life.
7. Subacute units and/or programs need

physician medical directors to assure quality of medical care, provide peer group liaisons, and coordinate and supervise patients and families input and needs.

8. Physicians provide a plan of care for medically necessary visits after completing an initial assessment within 24 hours of admission that identifies the medical services expected during subacute care.
9. Attending physicians should:
 - a. make an on-site visit to review the interdisciplinary care plan within 72 hours of admission.
 - b. Determine the number of medically necessary follow up visits; these may occur daily but never less often than weekly.

16) The House of Delegates did not adopt Resolution 802 which called for the AMA to develop a reduced, simplified, integer only system of disease and therapeutic coding for use by clinicians and to encourage all third parties to use this simplified form. The reference committee felt that the cost of development of such a system was too high in light of the lack of guarantee such a system could be implemented.

Timothy Wong MD

Reference Committee I

The House of Delegates in this Reference Committee considered the 34 recommendations of the Consortium to Study the Federation of Medicine. This consortium was formed to determine how the AMA and the Federation can be restructured so that the vast majority of physicians would be attracted/encouraged and join a national physician organization (the AMA) rather than fewer than the 50 percent of physicians who currently belong.

The 34 recommendations would have accomplished these goals by reconfiguring the AMA House of Delegates (HOD). Based on these recommendations this restructuring would have been accomplished by reducing representation in the HOD based on geography (AMA members in State Medical Societies) and increased representation by AMA membership in specialty societies, and eventually, based on

mode of practice and other aspects influencing physicians' lives.

Unfortunately, since the above changes would have reduced representation by some existing groups in the HOD, the specific changes recommended were not adopted but instead were referred for further study and to be considered at the Annual Meeting of the HOD in June 1996. The general principles of the consortium study however, were approved. The HOD action on the consortium's 34 recommendations as amended, are as follows:

Recommendation 1

Adopted: The Federation of Medicine should be restructured in a way that enables each medical association to retain its individual identity and activities, but which functions more like a total enterprise. The AMA should become the framework within which a new Federation of Medicine is established.

Recommendation 2

Adopted: The restructured Federation of organized medicine should be built on the basic components of the existing Federation: local medical societies/counties, state medical societies, specialty societies and the national umbrella organization (the AMA).

Additional components may need to be included.

Recommendation 3

Adopted: Individual physician membership should remain the predominant form for membership in all components of the Federation.

Recommendation 4

Included in Action on Recommendation 1

Recommendation 5

Adopted: The primary objectives of the new Federation should be: 1) an increase in value of membership, and 2) unity of voice and action of all Federation components.

Recommendation 6

Adopted: Physicians should be encouraged to join organized medicine at all levels of the restructured Federation. There should be initiatives to encourage maximal collaboration in membership development efforts among components

of the Federation.

Recommendation 7

Adopted: Federation participants must recognize that achieving real unity of voice and action and achieving true enhancement of the value of membership will require significant streamlining of roles throughout the Federation to reduce duplication (i.e., cost and dues) and create synergy.

Recommendation 8

Adopted: The roles of organizations serving physicians should be clarified and positioned to take full advantage of the strategic advantages enjoyed by each kind of organization. The Federation of organized medicine will be a catalyst and a forum for pursuing collaborative efforts to enhance the value of membership throughout the Federation. This effort will be the highest priority in the implementation process for creating the new Federation.

Recommendation 9

Adopted: The AMA House of Delegates should be composed of individuals representing organizations that reflect the major dimensions of a physician's life.

Recommendation 10

Adopted: The Federation House of Delegates should strive to be as inclusive as possible of physician organizations that have a stake in, and a contribution to make to, the goals of the Federation.

Recommendation 11

Adopted: State societies should be represented by one delegate for every 1,000 AMA members or portion thereof.

Recommendation 12

Adopted: State societies should continue to count AMA direct members from that state for purposes of determining delegation size.

Recommendation 13

Adopted: Specialty societies should continue to have representation in the AMA House of Delegates with a delegate allocation formula to be developed for the consideration of the AMA House of Delegates at its 1996 Annual Meeting.

Recommendation 14

Adopted: The current criteria for specialty society eligibility will continue to apply.

Recommendation 15

Specialty societies that cannot meet the minimum threshold of 500 AMA members may combine with other small societies to increase their size, seek representation through another larger specialty society, or agree to "share" a delegate with other specialty societies.

Not adopted.

Recommendation 16

Adopted: State societies should continue to be a "bonus delegate" for being unified. Specialty societies that are unified should also get a "bonus delegate."

Recommendation 17

Since many issues of concern to physicians are specific to their "mode of practice," participation of physicians by the category of mode of practice should be pursued by establishing "forums" that will assess the level of interest among physicians in those categories and develop recommendations for a more permanent participation mechanism, possibly including mechanisms that qualify for representation in the Federation House of Delegates. (Note: The initial "mode of practice" categories for the purpose of establishing forums should be: 1. solo and small independent practice, 2. small-medium size groups, 3. large groups that are medical groups only, 4. large groups that assume actuarial risk (i.e., managed care), 5. medical teaching, 6. research, 7. administration. These are initial suggestions only and are subject to revision.) Each group could conceivably develop a recommended representational approach unique to its particular characteristics and needs. The House of Delegates would ultimately decide on the acceptability and voting strength of each.

Referred to the Board of Trustees for consideration by the Project Team of the Study of the Federation project, with a report to the House of Delegates at the 1996 Annual Meeting.

Recommendation 18

Participation of physicians by demographic/ethnic/cultural characteristics would also be

pursued by assessing the level of interest and subsequently developing recommendations for more permanent voting or non-voting participation mechanisms.

Referred to the Board of Trustees, for consideration by the Project Team of the Study of the Federation project, with a report to the House of Delegates at the 1996 Annual Meeting.

Recommendation 19

Because of the potentially large number of new groups related to the "mode of practice" and "demographic/ethnic/cultural" categories, they would have to provide their own financial support. Further, it would be expected that any permanent participation or representation mechanisms to emerge from the preliminary analyses would include strategies to make them self-sustaining. The AMA Council on Long Range Planning should develop criteria to assist these groups and the House of Delegates in this effort.

Referred to the Board of Trustees, for consideration by the Project Team of the Study of the Federation project, with a report to the House of Delegates at the 1996 Annual Meeting.

Recommendation 20

Adopted: Consistent with the idea that "voting" is not the only way to participate in an organization, mechanisms should be established through which organizations or groups of physicians with particular interests can meaningfully participate in the Federation without having a vote in the House of Delegates. The AMA Council on Long Range Planning should be asked to identify such mechanisms.

Recommendation 21

A few groups that already have had a formal presence in the AMA for some time should have the option available to them of being formalized into sections under the current section format, procedures, and financial support arrangements. These include IMG's and women physicians. The AMA Council on Long Range Planning should be asked to explore whether minority physicians should also be considered for such an option.

Referred to the Board of Trustees, for

consideration by the Council on Long Range Planning and Development, with a report to the House of Delegates at 1996 Annual Meeting.

Recommendation 22

Referred to the Board of Trustees: The following organizations should be offered a voting seat in the Federation House of Delegates: The National Medical Association, the American Medical Women's Association, and the American Osteopathic Association. Other organizations of physicians should be considered for similar treatment as appropriate. The AMA Council on Long Range Planning should develop criteria to use in evaluating whether ethnically based physician organizations should be considered for organizational representation.

Recommendation 23: Not adopted

A maximum target of 625 should be established for the Federation House of Delegates. As the House approaches that size, it can decide what actions to take to maintain workability. (Note: The recommendations in this report would produce a House of approximately 535 initially.)

Recommendation 24

Adopted: Consistent with Section 2.73 of the AMA Bylaws, the Speaker of the House shall establish a special committee of the House to study ways to enhance the election process for positions on the AMA Board of Trustees and to study the size, composition, and terms of service of the AMA Board to enable it to function in the context of the new Federation of Medicine. At a minimum, a progress report on the work of this committee should be presented to the AMA House at its 1996 Annual Meeting. The final report of this committee shall be presented to the House no later than the 1996 Interim Meeting.

Recommendation 25

Included in Action on Recommendation 24

Recommendation 26

Included in Action on Recommendation 24

Recommendation 27

Adopted: The AMA Councils, and other governance elements, should be analyzed by the Council on Long Range Planning to determine if similar efforts to reflect

change should be made in each case.

Recommendation 28

Adopted: To establish a new, effective Federation of Medicine, a mechanism will be needed for the purposes of:

a. Clarifying roles and achieving active coordination of efforts:

i) developing a process of helping to coordinate the responses of medical associations to key issues,

ii) enhancing communication among medical associations and between medical associations and physicians,

b. Establishing a process for pursuing collaborative efforts among federation members:

i) identifying opportunities, including joint ventures, for medical associations to work together,

ii) promoting information sharing and compatible database development among medical associations.

Recommendation 29

Adopted: The current Project Team of the Study of the Federation shall provide a report at the 1996 AMA Annual Meeting that clarifies and provides more detail regarding specialty society representation and representation by major dimensions of a physician's professional life. Further, the Project Team should provide more specific details regarding how the new Federation should be implemented, including transition steps. In pursuing its work between now and the 1996 Annual Meeting, the Project Team should solicit broad input from components of the Federation to determine and assess their attitudes, desires, and intent regarding the principles of the restructured Federation. The report of the Project Team shall be made available to all Federation components well in advance of the 1996 Annual Meeting so that everyone will have the opportunity to review it thoroughly and be able to act on it at the 1996 Annual Meeting.

Recommendation 30

Included in Action on Recommendation 29

Recommendation 31

Included in Action on Recommendation 29

Recommendation 32

Included in Action on Recommendation 29

Recommendation 33

Included in Action on Recommendation 29

Recommendation 34

Included in Action on Recommendation 29

It is hoped/anticipated that, after the additional deliberations that will take place as a result of the actions of the HOD, changes will be made in the AMA/Federation of Medicine that will provide physician representation such that AMA membership will increase to the extent that medicine will be able to speak and act with a unified voice.

Stephen R. Permut MD

Report of AMA Reference

Committee on Constitution and Bylaws

Report 50 of the Board of Trustees discussed racial and ethnic disparities in health care. The report made a series of recommendations to counter disparities in health care and medical services including insurance coverage and infant mortality. The report and its recommendations were requested to be distributed to local physicians. Some of the recommendations include maintaining a position of zero tolerance toward racially or culturally based disparities in care and strengthening relationships with organizations representing minority physicians.

Medical students elected to various councils were given full voting rights as other physician members. The medical schools section also voted to add at-large members representing the interests of CME who need not have medical school faculty appointments.

A report on physicians' roles in managed care entities was referred to the Board of Trustees for further study. The report presented a variety of principles designed to assure that there is appropriate, organized physician input into managed care plans. There were, however, many concerns that the principles were too broad and at times too specific.

There were several reports from the council on ethical and judicial affairs. CEJA reaffirmed the policy of physicians not treating themselves or immediate family members

except in emergencies and in cases of routine care for short-term, minor problems. CEJA reversed its opinion on the use of anencephalic infants as organ donors to keep the AMA's position in line with the United Network for Organ Sharing. Retrieval and transplantation of the organs are permissible only after a determination of death is made. The council reconsidered its opinion on the use of drug samples and clarified its guidelines as follows: personal or family use of drug samples is permissible as long as these practices do not interfere with patient access to drug samples.

Several resolutions were adopted to clear up the election and terms of offices for the OMSS, MSS, and RPS. Another resolution asks the AMA to voice its strong opposition to any corporation which misrepresents physicians by failing to list their professional degrees in the corporation's advertising directory. And finally a reaffirmation of existing policy against self-referral unless there is the absence of adequate alternative facilities, and unless the physician needs to have personal involvement with the provision of care on site.

Michael J. Bradley DO

Reference Committee

Science and Technology

This committee had many reports and resolutions which it considered. I will attempt to summarize the important issues of each. The budget for 1996 includes \$202.4 million in expenses with \$2.5 million left for reserves. The reorganization of the AMA over the past several years has yielded a much leaner and efficient AMA. The AMA dues programs for group practices of 100+ members has been very successful and will be expanded to groups of 50+. In addition, the expansion of the four plus one program to all physicians will allow the individual or small group to save 20 percent on their dues. A request for observer status by the American Podiatric Medical Association was referred back to the Board of Trustees for further review.

There has been a great deal of discussion concerning the issue of campaign expenditures for AMA elections. There have been reports of excessive expenditures and the potential

negative impact this may have on the democratic spirit of the House of Delegates and the AMA in general. These expenditures present a hardship for smaller, less affluent state societies and specialty organizations who wish to nominate and support candidates. The House decided to have the speaker monitor the upcoming elections and report back at I-96 on the expenditures and recommendations to the House.

Two resolutions to expand the House were defeated. The first would have given an additional delegate to a constituent society if two-thirds of its members were AMA members. Present policy requiring 75 percent membership was retained. The second would have given one delegate for every 800 members, rather than the current 1000.

Many times a Board of Trustee report or council report contains errors of fact or contains portions which can be misinterpreted. These reports are usually filed as such because there has never been a mechanism to correct the body of a report until now. Limited corrections or revisions can now be presented to the House for action at the same meeting. All our members should know that all AMA policies have a ten year sunset review. The council on Long Range Planning reviews numerous policies and updates them for the House to act on each year.

Michael J. Bradley DO

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MSD MONTHLY ACTIVITIES

Working for You: February 1996

Leadership Activities

- Mr. Meister met with Bob Rock of the Delaware Health Plans Consortium to discuss DHPC's progress to date.
- Mr. Meister met with Paula Roy, executive director of the DHCC, to discuss HB 321.
- Carol A. Tavani MD and Mr. Meister met with Ben Corballis MD and Charles Reese MD to discuss legislation regarding the definition of emergency.
- Beverly Dieffenbach attended DHCC Certificate of Need Committee meeting.
- John Kramer MD represented the Society at the International Conference of Physicians' Health Program Directors.
- Carol A. Tavani MD met with the leadership of the MSD Alliance to discuss fund raising possibilities.
- Mr. Meister attended the monthly meeting of the DHCC.
- Carol A. Tavani MD and Mark Meister met with the president and chairman of the ADH to discuss current issues.
- Mr. Meister met with the Senior Trust Administrator of PNC Bank to discuss funding of health related projects through a private trust.
- Mr. Meister and Jana Siwek met with representatives of the Pennsylvania Medical Society to discuss the Society's initiative to develop physician organizations in Delaware.
- Mr. Meister met with Representative Maroney to discuss HB 321.
- Mr. Meister represented the Society at a meeting of the Welform Reform Task Force of the Delaware Public Policy Institute.
- Mr. Meister met with Bob Reed of BCBSD to discuss development of a community health information network for Delaware.

- William H. Duncan MD and Mr. Meister met with representatives of the Medical Society of New Jersey to discuss offering the MSNJ's wholly owned malpractice insurance program to Delaware physicians.
- John Kramer MD met with representatives of the Board of Medical Practice to discuss the Board's relationship with the Society regarding physician health issues.
- Michael J. Bradley DO and Mr. Meister testified before the House Banking and Insurance Committee regarding HB 321.

Physicians' Advocate Program Activities

- Insurance carriers and EDS were polled for information to be used in an educational patient packet for the Diamond State Health Plan. This information will aid physician's offices in dealing with Medicaid population.
- Attended the DMGMA meeting and provided a legislative update.
- *Physicians' Advocate* provided consulting at the Medical Society for two new physicians, regarding the establishment of a new practice. Consulting was also provided to a physician on practice management.
- At the request of a physician, a questionnaire pertaining to Diamond State Health Plan enrollment figures was sent to participating carriers.

Continuing Medical Education Activities

- Sponsored 22 educational activities for Category 1 credit.

IN BRIEF

American Cancer Society's National Conference on Cancer Prevention and Early Detection

The conference will be held April 18 to 20, 1996 at The Renaissance Hotel at Techworld in Washington, DC. For further information write:

American Cancer Society National Conference on Cancer Prevention and Early Detection,
Attn: Andy Cannon, American Cancer Society, 1599 Clifton Road, NE, Atlanta, GA 30329-4251.
Telephone: (404) 329-7604; Fax: (404) 329-5785. Or contact the Delaware Division, Inc., 92 Read's Way, Suite 205, New Castle, DE 19720; or call (302)324-4227.

Ninth Summer Institute in Environmental Health Sciences To Be Held

Ten courses will be presented June 3 to 14, 1996, at Johns Hopkins School of Hygiene, Baltimore, Maryland. For more information call Denise Barton at (410) 955-3537.

33rd Annual Infectious Disease Symposium

On May 7 to 9, 1996, the Infectious Disease Symposium will be presented at the Delaware Academy of Medicine, 1925 Lovering Avenue, Wilmington, Delaware. For more information contact William J. Holloway MD, Director, Infectious Disease Research Laboratory, Medical Center of Delaware, 501 West 14th Street, Wilmington, Delaware 19899. Or call (302) 428-2744.

Third Annual Intensive Review of Internal Medicine: An Update for Clinicians

This conference will be held June 19 to 22, 1996 at the Crystal Gateway Marriott in Arlington, Virginia. For more information contact Deborah Karpowicz, The George Washington University Medical Center, Office of CME, 2300 K Street, NW, Washington, D.C. 20037, or call (202) 994-4285.

NIH Consensus Panel Issues Report — Consensus Development Conference on Cochlear Implants in Adults and Children

A National Institutes of Health (NIH) consensus development statement on Cochlear Implants in Adults and Children may be obtained from the NIH Office of Medical Applications of Research (OMAR).

The report was prepared by a panel of experts who considered scientific evidence presented at a Consensus Development Conference at NIH. It contains recommendations and conclusions concerning cochlear implants in adults and children.

NIH consensus conferences bring together researchers, practicing physicians, representatives of public interest groups, consumers, and others to carry out scientific assessments of drugs, devices, and procedures in an effort to evaluate their safety and effectiveness.

The Impact of Genetic Technology on Civil Liberties

This symposium will be held Friday, April 19, 1996 at the Widener University School of Law. The fee for the program is \$100.00.

For more information contact Thomas Leff at the American Civil Liberties Union at (302)654-3966.

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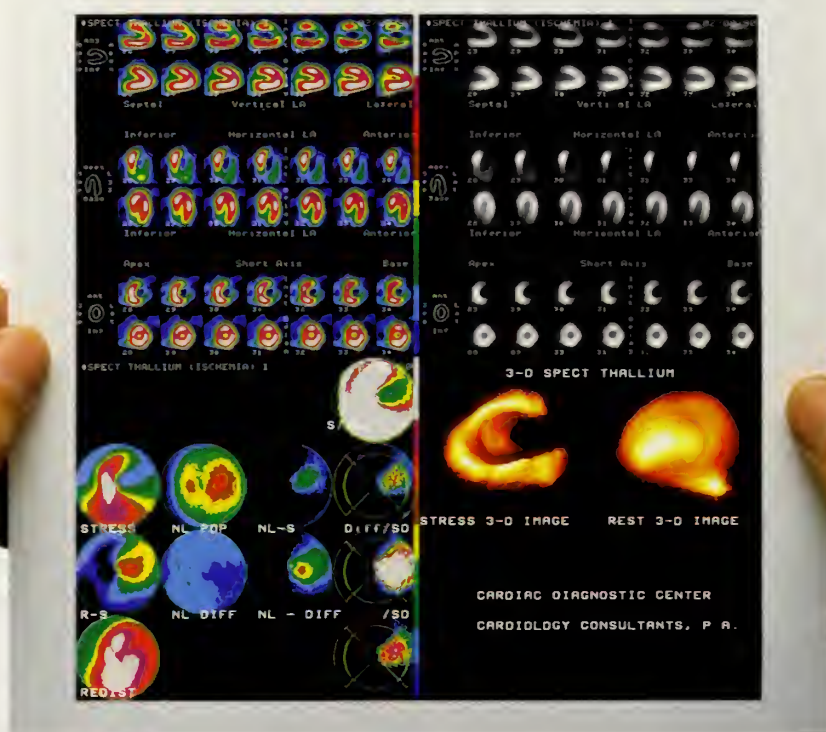
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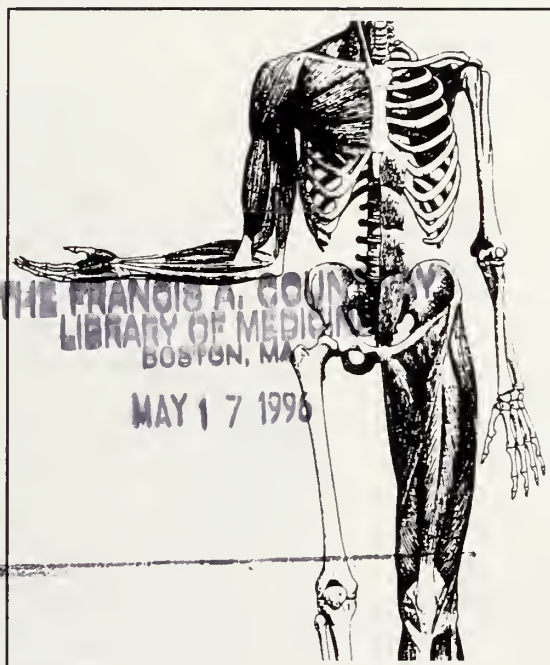
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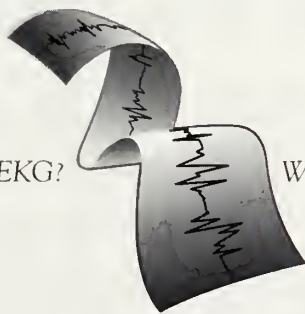


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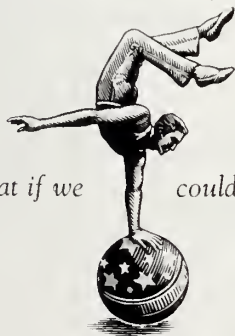


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Too Few "Bad Doctors" in Delaware?

A recent *News Journal* article provided the impetus for this month's President's Page. The Federation of State Medical Boards released its annual report concerning disciplinary actions taken in each state. Only the District of Columbia had a rate lower than that of Delaware. Critics of the medical profession are quick to infer that this low number indicates a shortcoming on the part of the Board of Medical Practice to identify and act upon physician misconduct, as well as a failure of the profession to police itself. However, it should be pointed out, as Jane Harriman did in her coverage of this topic, that lowest may not necessarily mean worst at all. The Board of Medical Practice in Delaware works diligently to ensure that physicians in this state measure up to quality standards and conduct themselves professionally. This protection of the public, by way of investigation and follow-up of complaints, is a labor-intensive and difficult task.

Since 1980, this process has been aided by an important committee of the Medical Society, one that has been a keen interest of mine, and of which I have had the privilege of serving as chair for a number of years, and that is the Physicians' Health Committee, formerly called the Impaired Physicians' Committee (the name was changed to denote the fact that physicians need not be impaired to avail themselves of the services the committee provides, and in fact intervention long before impairment eventuates is desirable). During the year of my presidency, Dr. John Kramer capably serves as interim chair.

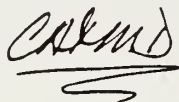
The committee and the board have forged a collaborative working relationship, which has come to be based on mutual trust, respect, and the recognition of common goals, most notably the welfare of the public. Years ago, these two bodies had little communication, and there were those who held the view

that the committee shielded doctors who were incompetent or unprofessional. Matters began to improve when the chairs of the committee and the board began to meet regularly to discuss issues of mutual concern as well as individual cases about which the board needed to be apprised. Out of this attempt at establishing communications emerged a wonderful improvement: a two-way street, wherein not only did the board gain reassurance of the committee's work in helping physicians with problems before they became impaired by them, and in the knowledge that the committee would in fact apprise the board of physician impairment when it had knowledge of it, but the board, in turn, began to refer physicians to the committee for help with problems of which it became aware. Similarly, as the committee's work and advocacy efforts became better recognized, self-referrals by physicians began to occur, obviously illustrating an increased degree of trust. Thus it became evident that the best interest of the public is not always served by licensure revocation in the face of a problem; in fact, in a recent collaborative effort of the two bodies, a troubled physician whose removal would have represented a serious disservice to many patients was able to be returned to practice with absolutely no compromise to patient care quality.

The practice of medicine is inherently stressful, with no room for error, demands which are often difficult, sacrifice of personal needs, and increasing difficulty, in the continuing encroachment by managed care, of the ability to control the quality of care rendered. Most would say that the privilege of caring for patients is reward enough, but the price physicians pay for that privilege has risen, and the psychological morbidity of our profession is high. The scope of problems seen by the committee is quite varied and in-

cludes: depression, bipolar illness, litigation stress, marital difficulties, substance abuse, sexual disorders, personality disorders, and a host of other difficulties. The age range of physicians encountered likewise varies; problems of the aging physician have been encountered and can be expected to rise as the population grays. Physicians-in-training are also referred for help. These interventions are conducted in the utmost confidentiality, and in the vast majority of cases no action is necessary with regard to the physician's licensure, and the public has no need to lose what is in most cases a valued resource.

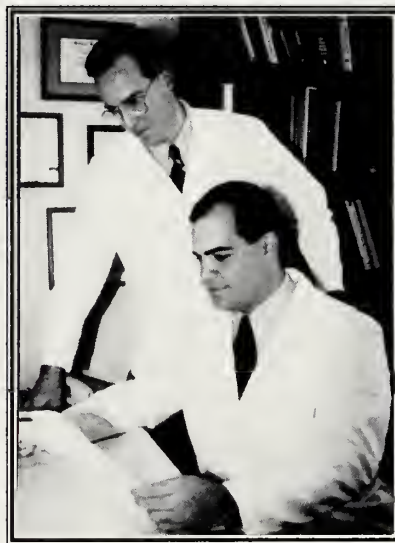
The members of this committee are a dedicated group, ready with very little notice to pitch in and help a colleague in need. I am proud of the fine work they have done and continue to perform. In short, Delaware's low "bad doctor" rate may well be more reflective of a job well done (both by the Board of Medical Practice and the Physicians' Health Committee) than of the more sinister implications some critics would imply.



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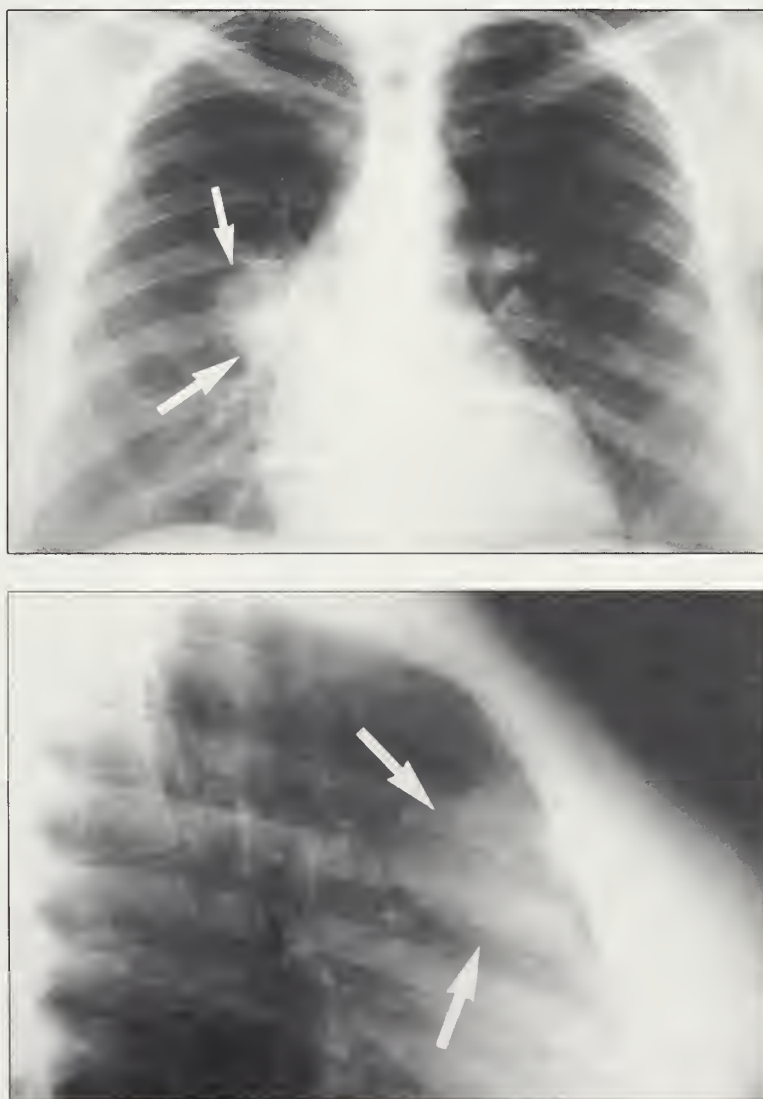
Case Report: Plasma Cell Granuloma of the Lung

Anthony J. Scola MD

Case Report

A 17-year-old African-American female was evaluated in the emergency room for several episodes of hemoptysis which occurred after running. The patient denied any past medical history or recent pulmonary disease. There was no associated shortness of breath, chest pain, fever, weight loss or night sweats. There was a positive family history of maternal sarcoidosis. Travel history was noncontributory. Physical examination and routine laboratory values were unremarkable.

PA and lateral chest radiographs demonstrated a well circumscribed 5 cm right perihilar mass (Figure 1). Computed tomography of the chest was performed the same day, which revealed a sharply margined noncalcified cavitary parenchymal mass in the anterior segment of the right upper lobe. The medial border of the mass was confluent with the adjacent mediastinum, where adenopathy was noted. The mass also abutted the pleura anteriorly (Figure 2). Pertinent negatives included absence of other pulmonary masses or pleural effu-



Dr. Scola is a physician in the Department of Radiology, Riverside Hospital, Wilmington, Delaware. **Figure 1a and 1b.** PA (a) and lateral (b) chest x-ray demonstrates a large mass in the anterior segment of the right upper lobe (arrows).

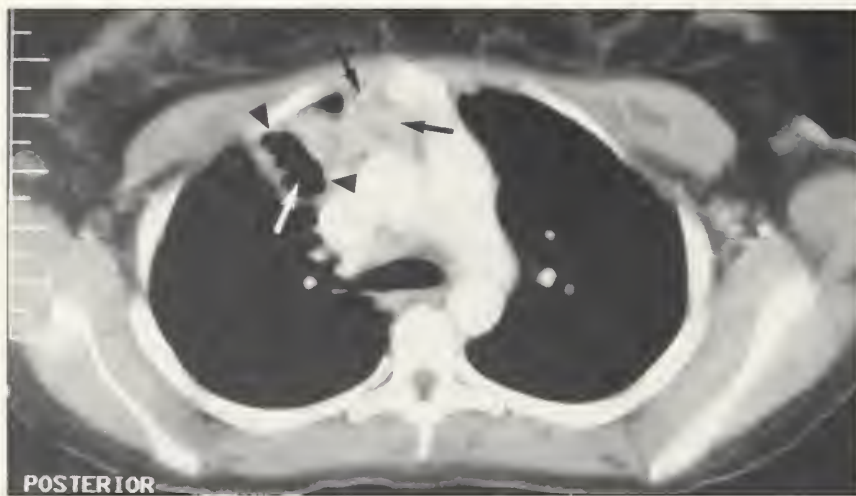


Figure 2. Contrast enhanced CT scan of the chest shows cavitary nature of the mass (white arrow) as well as its intimate relationship to the mediastinum and anterior pleural surface (arrowhead). Anterior mediastinal adenopathy is also seen (black arrows).

sion. The major diagnostic considerations were between neoplastic and infectious etiologies, with congenital lesions such as bronchogenic cyst felt to be unlikely.

Bronchoscopy was performed the next day. No endobronchial lesions were noted, although fresh blood was seen emanating from the bronchus to the anterior segment of the right upper lobe. For technical reasons, a transbronchial biopsy could not be performed. Brushings and washings were negative for malignancy, and Gram stain and cultures were unrevealing. A PPD was negative, and titers for coccidiomycosis, blastomycosis and histoplasmosis were normal.

Three days afterwards, a right thoracotomy was performed and the mass sampled. Frozen section revealed spindle cells with chronic inflammation seen peripherally. Many foamy macrophages were also present. Although mitotic figures were scant, it was felt that a sarcoma could not be entirely excluded.

Visually, thymic invasion and anterior mediastinal adenopathy were felt to be present intraoperatively, so a right upper lobectomy with thymectomy and lymph node dissection was performed. The patient's post-operative course was complicated by persistent pneumothorax necessitating prolonged chest tube placement.

Final pathologic diagnosis was delayed

while awaiting a second opinion from an outside laboratory. The mass was a plasma cell granuloma AKA inflammatory pseudotumor. Mediastinal lymph nodes were hyperplastic but negative for malignancy. The thymus was negative for neoplasia as well.

Discussion

Plasma cell granuloma (PCG) is a benign nonneoplastic lesion which occurs most commonly in the lung parenchyma, with the next most frequent

site being the bronchial tree. Other primary anatomic foci are possible (e.g., liver, stomach, kidney, meninges) but are quite rare.¹

A retrospective review of 181 cases² has established several demographic observations. The age range was between 1 to 73 years, with the average being 29.5 years old. Sixty percent of patients were younger than 40 years old, and 8 percent were younger than 10 years old. (An earlier review subsumed by this study noted that 25 percent of all cases occurred in patients less than 10 years of age,³ and this figure is still frequently quoted.) It is the most common isolated primary tumor-like lung lesion in patients younger than 16 years old. There is no sexual, ethnic or geographic predilection. The right lung is slightly more affected than the left. Nearly three-fourths of all PCGs were asymptomatic at time of discovery. Of those with symptoms, a nonproductive cough was most common. Fever, low level chest pain, shortness of breath and hemoptysis have occasionally been described. There has been a report of hypertrophic osteoarthropathy with arthralgia, clubbing and typical osseous radiographic changes, all of which resolved post-surgically.⁴ Isolated clubbing is sporadically seen.

Nearly 70 percent of all patients had no history of prior pulmonary disease. Of these with previous pulmonary problems, the

elapsed time prior to presentation ranged from one month to 34 years, although a significant number occurred within a year following the illness.

Laboratory data is typically normal, although occasionally elevated immunoglobulins and erythrocyte sedimentation rate can be seen, as well as thrombocytosis.⁵ Sputum analysis may be helpful in making other entities such as malignancy or active inflammation less likely, but are non-specific in the diagnosis of PCG.²

Plasma cell granuloma has received many other appellations in the medical literature, including histiocytoma, xanthoma, fibroxanthoma and xanthogranuloma. These latter names were derived from observations of large amounts of cytoplasmic fat within macrophages, but the most constant and frequently striking cellular component is the mature plasma cell.³ On permanent histologic sections, spindle-shaped cells are seen quite often as well.² The most common alternate nomenclature for this entity is inflammatory pseudotumor, but this term presupposes an etiology that has never been satisfactorily proven, given that the majority of patients have no history of a prior pulmonary disease, and attempts to culture a causative organism in the masses have repeatedly failed.^{2,6} Nevertheless, chronic inflammatory cells are a persistent histologic finding.

The most common chest x-ray appearance of PCG is a well circumscribed mass, although no true capsule is present pathologically. Size ranges from 0.5 to 36 cm, with most being less than 6 cm. Occasional ill-defined borders are noted, but these are probably from adjacent atelectasis or post obstructive pneumonia from an endobronchial component or bronchial compression. In the few cases that have been followed serially, stable size is normally seen, with occasional reports of slow growth over months to years. Cavitation is rare.^{2,3}

Calcification is uncommon, and is better appreciated with CT. Appearance is variable, but it is generally speckled and randomly scattered, although some authors report rather dense calcification.⁷⁻⁹ The more typical pattern may help to differentiate from the

classic target lesion of infectious granulomas and the "popcorn" appearance of hamatomas. Calcification is much more readily seen histiologically than radiographically.⁸

On CT, lack of enhancement of a soft tissue density mass after intravenous administration of iodinated contrast is the anticipated appearance, although a thick rim of enhancement has been reported, felt to be secondary to an inflammatory pseudocapsule.⁹ The absence of a pleural effusion is strikingly consistent, leading some authors to suggest doubting the histologic diagnosis if an effusion is present.^{2,4}

Except for CT, additional imaging modalities have added little in suggesting the diagnosis. Intense tracer uptake in a calcified PCG has been noted on bone scan.¹⁰ F-18 fluorodeoxyglucose radioisotope is taken up by lung malignancies with a reported 90 percent specificity during position emission tomography (PET), although a false positive scan has been noted with recurrent PCG.¹¹

Although nonneoplastic, PCG's can display aggressive features, such as extension into the mediastinum, chest wall, bronchi or even thoracic vertebral bodies. This is thought to occur in 5 percent of all cases. No instances of malignant degeneration or metastases have ever been reported. While recurrence has been noted, it is decidedly unusual in the setting of complete surgical resection.^{2,4,12}

The ability to correctly diagnose the lesion preoperatively has met with mixed success. Percutaneous fine-needle aspiration cytology of PCGs has generally yielded poorly cellular smears with no characteristic findings, with there being a mixture of chronic inflammatory cells and tissue fragments, and a low number of plasma cells. The nuclear/cytoplasmic ratio was normal, and no signs of malignancies were noted. Percutaneous needle biopsy specimens yield similar findings. While these results may strongly suggest the proper diagnosis in the appropriate clinical and imaging setting, the possibility of sampling of a reactive zone surrounding a malignancy must be considered.^{6,13} Additionally, the distinction between PCG vs. lymphoma and malignant fibrous histio-

cytoma may not be possible,^{14,15} and thoracotomy is generally the next recommended step. Intraoperative frozen sections can be helpful in excluding malignancy and thereby limiting the extent of resection, but false positive and "possibly malignant" interpretations are not uncommon.^{2,10,12,16}

Although nonmalignant, current recommendations are for total surgical removal of PCG, not only to confirm the diagnosis but to prevent potential complications from mass effect and local invasion.^{2,12,14,15,17} Total excision is curative, although long-term follow-up is recommended, due to sporadic reports of recurrence.¹²

There has been a report of spontaneous resolution of PCG following thoracotomy and open biopsy,¹⁸ but such a response should be considered highly atypical. There are also cases of total¹⁹ or significant²⁰ resolution after weeks of oral corticosteroid therapy, although this is probably best reserved for lesions that would be difficult to totally resect, either due to its invasive nature or poor clinical condition of the patient. PCGs are also radiosensitive, but use of this modality is again best limited to problematic cases,¹² especially given the significant number of pediatric patients in which the potential for growth disturbances of the hemithorax exists.^{1,17}

In conclusion, plasma cell granuloma (inflammatory pseudotumor) of the lung is a benign mass of uncertain etiology. Patients often lack symptoms, and laboratory data are frequently normal. Imaging characteristics are varied but it typically appears as a well circumscribed non-enhancing soft tissue density mass. Calcification, cavitation, mediastinal invasion and lymphadenopathy are uncommon but possible. Preoperative diagnosis may be suggested in the proper clinical and imaging setting, particularly in the pediatric population. Surgical resection is generally both diagnostic and curative. Although recurrence has been reported, malignant degeneration and metastases are unknown with PCG.

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Special acknowledgement to Chris Kulko for the typing of this manuscript.

A Medical Ethics Report

Maurice Liebesman MD

Among the many complex medical ethical issues, no one is presently more controversial than the determination of brain death and the use of anencephalic infants as organ donors. To address these issues, two outstanding pediatric ethicists were invited to be speakers at the "Dr. Margaret Handy Annual Memorial Lectureship" held at the A. I. duPont Institute on March 1, 1996: Madelyn Kahana MD, Associate Professor of Anesthesia and Critical Care, and Lainie Friedman Ross MD, Assistant Professor of Pediatrics, both from the University of Chicago Hospital. Their presentations were followed by many questions which showed the interest of the attendees on this matter.

By coincidence, Alan R. Fleischman MD, neonatologist, member of the New York Academy of Medicine and member of the Executive Committee of the AAP Section on Bioethics commented in its last newsletter that although anencephaly is easily diagnosed (absence of skull, scalp and forebrain with lack of functional cortex), these infants have relatively intact brain stems and often breathe spontaneously at birth and have many primitive reflexes. While it is estimated that 300 to 500 infants with anencephaly are born alive each year in the United States and with organs healthy enough for transplantation, there are also hundreds of infants born with congenital abnormalities correctable by transplantation. To complicate things, recent studies have confirmed that anencephalic infants, by the generally accepted criteria, are not "brain dead." If we were to take into consideration the principle of the Uniform Anatomical Gift Act which states that

life-sustaining organs may not be taken from a living person for the benefit of others, it is clear such principle would prevent us from using an anencephalic infant as an organ donor ... unless you believe, as other well-intentioned clinicians do, that these infants, although born alive, never experienced "consciousness." The dilemma is: on one hand, we have the ability to save infants with failing organs for whom replacement technology would be life-saving and available; and on the other hand, the moral cost. In any given day at any Neonatal Intensive Care Unit, two infants will die: one, because anencephaly is incompatible with life, the other because of lack of an organ donor. What a dilemma!

The position of the Committee on Bioethics of the American Academy of Pediatrics was published in *Pediatrics* 1992, 89: 1116-1119 and states:

"At this time a convincing case for changing the law has not been made ... The costs of amending the law on organ retrieval or definition of death can only be estimated. Such an amendment might produce decreased respect for human life in other areas or it might have no such effect. It should also be noted that an amended law could trigger public fears that organs are or will be taken from other humans not fully brain dead. As a result, donations in general might fall, further reducing the overall gain in lives saved from changing the law ... Sufficient questions exist to counsel extreme caution before adopting a policy permitting organ retrieval from anencephalic infants who retain brain stem function."

Do you care to comment? If so, please let us know. Write the Delaware Medical Journal, 1925 Lovering Avenue, Wilmington, Delaware, 19806.

Dr. Liebesman is the Medical Director of Principal Health Care and Chairman of MSD's Medical Ethics Committee.

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Glimpses of 20th Century Medicine and a Preview of the 21st Century

Davis G. Durham MD, FACS

My first introduction to medicine was hearing my father answer the upstairs phone during the night and ask, "What do you have in the house? Put a mustard plaster on the chest and I will see you in the morning."

Scientific medicine scarcely existed at that time. As I look back now, medicine in the early 1900s was fairly simple. An individual solo practitioner, the beloved family doctor, was so busy caring for his patients that he was unaware of the great changes about to take place in medicine and in society. Although he was skilled in the art of medicine, the scientific medicine he practiced was based on limited teaching received in medical school. He was made aware of the specific cause of tuberculosis, syphilis, pneumonia, typhoid fever and polio. He was also encouraged to vaccinate against smallpox and typhoid fever. For the most part, the drugs used were symptom-relieving medications that included derivatives of opium, digitalis, aspirin and bromides for sedation. The treatment of diseases was limited. Syphilis was treated with arsenicals and mercury, and quinine was used to treat malaria. Since there was considerable surgical mortality, surgery was limited to the removal of diseased organs such as the acutely inflamed appendix. Often the self-taught surgeon provided a placebo effect by his presence and by assurances.

Figure 1 shows me at four years of age with my father. As you can see, I was destined to be a doctor from a very early age. My father was the epitome of the family doctor,

lovable, always available without much in the way of medicinal treatment. As a solo practitioner in Warren, Pennsylvania, he did some general surgery — usually self-taught. He started making house calls on a bicycle and later graduated to a horse and buggy (Figure 2). Finally in 1912, he acquired an automobile. Since he was the first person to have a telephone on his side of town, it disturbed him if neighbors asked to borrow his phone to call another doctor! At the age of 17, without assistance, he delivered his first baby in rural Canada. My father was with his cousin, a rural practitioner, when the attending doctor was called away for another delivery. If a call came from another expectant woman, my father was to take care of it. Of course, the



Figure 1. James R. Durham Sr., MD, and the author at age 4.

Dr. Durham practices ophthalmology in Wilmington, Delaware. This article is based on his presentation in July, 1995 at the Academy of Life Long Learning.



Figure 2. James R. Durham Sr., MD's, mode of making house calls.

woman had had other babies and she probably knew more about the delivery than he did.

Since my father had perceived a decrease in respect for physicians, he tried to discourage my brother, J. Richard Durham MD, and me from going into medicine. Then again, he was not able to foresee the tremendous advances that were to occur in medicine in the latter part of this century.

In 1900, my father diagnosed his own acute appendicitis. Since none of the local physicians could perform an appendectomy, he imported one from Buffalo, a city that was 90 miles away. Although at that time the diagnosis of appendicitis carried a high mortality, he survived.

The Medical Fee Bill which was printed for his county and displayed prominently in the office stated: Office Visit 50 cents, House Call \$1.00, Setting of Fracture \$5.00.

Epidemics of diphtheria and scarlet fever, and to a lesser extent measles, were terrible. Some may remember the great influenza epidemic of 1918. It was caused by the so-called "Spanish Flu" and resulted in 20 million deaths worldwide with over one-half million in the United States! This was more than the total killed in World War I. Other influenza epidemics were the 1957 "Asian Flu" that resulted in 70,000 deaths in this country. The

milder 1969 "Hong Kong Flu" caused 28,000 deaths. Unfortunately, there is no treatment for influenza; only type-specific prior immunization affords protection. Death from influenza was from the streptococcal pneumonia that often accompanied or followed the viral infection.

The pandemic of 1918 has been called the greatest medical holocaust in history. There is probably no disease in which symptoms occur more suddenly. My father told a story of four women playing bridge who contracted influenza so abruptly that the next day there was a funeral for all four. Most of those that died were in the 25 to 44 age group. At least the influenza epidemic had one beneficial effect, as it showed the need for public health measures in this country. Other diseases that carried a high mortality were pneumonia (50 percent) and diphtheria, which killed 20,000 children annually in the United States.

Few significant changes occurred in medicine until the late 1930s. The notable exceptions were the Flexner Report of 1910 and the discovery of insulin. Abraham Flexner (Figure 3), an educator, was commissioned by the Carnegie Foundation to survey the quality of the 155 medical schools in the country. The Flexner Report had a sensational impact on U.S. medical education as it prompted the closure of many schools. Often these medical schools were owned by physicians who operated them for profit. The remainder of the medical schools initiated extensive revision of their policies and curricula, and many be-



Figure 3. Abraham Flexner.

came associated with a university. Strong financial support, especially one-half billion dollars from the Rockefeller Foundation, permitted new buildings, hospitals and research as well as funding for full-time faculties. The Flexner Report was the most important factor in advancing medical education in this country and in laying the foundation for the U.S. to become a world leader in medical education and research for the remainder of this century. In addition, Flexner established the Institute for Advanced Study at Princeton and from 1930 to 1939 was the first director. He attracted Albert Einstein to the Institute in 1933.

The second major event in the first third of the century was the discovery of insulin by Banting and Best in 1923 (Figure 4). Before the discovery of insulin, the prognosis for diabetics was dismal. The patients often died within two to three years of severe chemical imbalance. It should be noted that of 25,000 obstetrical deliveries in the London Maternity Hospital in one year, none was to a diabetic mother. If a diabetic woman became pregnant, the baby was usually stillborn.

In the late 1930s, the antibiotic era began. The discovery of prontosil and then sulfanilamide firmly established antibacterial chemotherapy as a clinical reality and provided the stimulus for the subsequent development of many other antibacterial agents.



Figure 4. Banting and Best — Discoverers of Insulin.

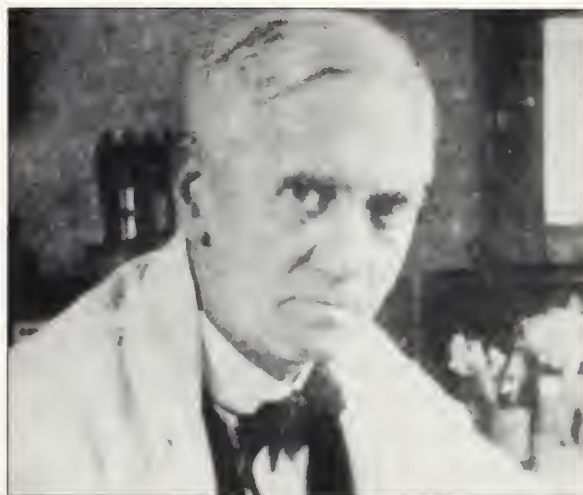


Figure 5. Fleming — Discoverer of Penicillin.

Massengill Company's "Elixir Sulfanilamide Disaster" occurred in 1937. Its use of diethylene glycol as a solvent resulted in 105 deaths. The incident led the Federal Food & Drug Administration to require proof of safety before approving a new drug.

When Alexander Fleming (Figure 5) discovered penicillin in 1929, its significance was not widely recognized. Although Florey and Chain purified it in 1939, full-scale commercial production did not begin until 1945. It was available, though, to the military by D-Day. During the latter part of World War II, it had a tremendous impact on treating the wounded.

It can be said that Fleming put penicillin on the map and Florey put it on the market. At Oxford, when penicillin was first used (before commercial production) it was recovered from the urine of treated patients. Since two-thirds of the penicillin administered was recovered, it was a major source of the antibiotic. There was an Oxford woman whose job was to go from hospital to hospital every morning to collect the urine of patients taking penicillin. Some called it, facetiously, the "morning milk round"; others called it the "pee patrol."

Young surgeons today have little understanding of how surgery was practiced before the days of sulfonamides and antibiotics. I can remember my father describing cases of "laudable pus." This was copious pus forma-

tion in a wound that surgeons of that era considered a favorable sign of the body's defenses!

Penicillin changed the treatment of infectious diseases. For instance, the mortality from streptococcal infections with bacteremia was as high as 25 percent. President Coolidge's son, while at the White House, died from an infected blister on his heel that he acquired playing tennis. After penicillin was available in 1944, such deaths became rare. Acute appendicitis carried a mortality of about six in every 16 diagnosed with the disease. A chest infection, such as empyema, was virtually a death sentence. Penicillin changed the whole picture. Surgery as we know it today would have been impossible without antibiotics. By March 1944, over 400 billion units of penicillin were produced monthly and with that the management of disease was changed forever.

Other antibiotics followed penicillin. Streptomycin, developed by Waksman, was introduced in 1944 and tetracycline in 1948. Today, the subject is so complicated that there is an infectious disease specialist on the staff of most major hospitals. The battle against disease and illnesses has brought more victories in the last 50 years than in all prior human history. So, we are living in very interesting times. Prior to the introduction of sulfas and antibiotics, doctors were virtually helpless in their efforts to cure the simplest infectious diseases. Of course, with these developments and ever broadening knowledge, specialization has become necessary. The personal contact between patient and doctor, which was always so valued in the past, has, in turn, been reduced.

My father lived to see and practice in the antibiotic era. Although retired since 1932, he took over my brother's (J. Richard Durham Jr.) general practice when Richard went into the Air Force as a flight surgeon in 1942. Until 1946, he delivered babies, did general medicine and even worked as a part-time physician under Dr. Lemuel McGee for the Hercules Company.

In more recent times, a major development was the work of Watson and Crick, who defined the nature of DNA and the double he-

lix. The Salk vaccine, which was based on the work of many others, was a great advance toward the elimination of poliomyelitis (Figure 6 — iron lungs). The World Health Organization hopes to eradicate this disease in America by the year 2000. Perhaps many will remember the polio epidemic of the summer of 1952. Wilmington's theaters and swimming pools were closed as they were considered a source of the spread of the epidemic. As an aside, a commentary this year in the *Wall Street Journal* was of interest. A high school teacher in a questionnaire to his students, asked "Who was Jonas Salk and what were iron lungs?" Not one student could identify Jonas Salk and one boy suggested that scuba divers strapped iron lungs on their backs. One can go from "who's who" to "who is that" in no time.

The most significant accomplishment in infectious disease has been the eradication of smallpox in the 1980s. As recently as 1967, 10 million cases were recorded with 2 million deaths from this disease. This is the first time any infectious disease has been eradicated from the world. It represents a tremendous milestone of international cooperation in a public health effort.

The use of radiation therapy and chemo-



Figure 6. 1952 — Polio epidemic and iron lungs.

therapy offers some hope for cancer patients. Understanding genetics and the intricacies of DNA will help to unravel many diseases in the future. We have seen and witnessed the growth of transplant surgery. MRIs and CAT scans have tremendously improved our diagnostic abilities.

Pacemakers were introduced in 1961. My pacemaker was inserted eight years ago. I was told that I would be dead without it. Arthroscopy has been a tremendous advance in the evaluation and treatment of joint disorders. One of the first to use arthroscopy was Dr. Ward Casscells, a Wilmington orthopedic surgeon. He was founder and first editor of *Journal of Arthroscopy and Related Surgery*. Wilmington is also honored in having the father of pediatric ophthalmology, Dr. Robison D. Harley. Although he recently retired, his textbook is now going into its fourth edition. The second edition was 1,700 pages.

The Wilmington area with its nearly 1,000 PhDs offers opportunities for research in conjunction with engineers from the DuPont Company. With their help, a test for glaucoma using the Pneumatic Applanation Tonometer was developed. I introduced Diamond knives manufactured by the DuPont Co. into eye surgery. Since human research is difficult in this country, the testing was done in Africa. Today, modern cataract surgery is made feasible by these knives; they also have other medical applications.

Laparoscopic surgery has been a big advance; it permits procedures such as an appendectomy or cholecystectomy to be done with minimal trauma. A speedy rehabilitation usually follows. The fundamental change was the use of the new technology of fiber optics that used a cold light source rather than the previously used hot incandescent lamps.

On March 15, 1971, John M. Levinson MD, who had been working with the Johns Hopkins group, performed the first laparoscopic female sterilization in Delaware. He started dozens of laparoscopic sterilization clinics in Asia and introduced laparoscopy to China. By 1975, he had lectured and written about non-gynecologic laparoscopy. He was also doing liver biopsies and other procedures through the laparoscope. Well over 100,000

cases of laparoscopy have now been performed in Delaware. In recent years, many laparoscopic procedures have been performed by gastroenterologists and by general surgeons who commonly do cholecystectomies via the laparoscope. The influence of Delaware expertise in this procedure has been profound.

Implants have changed the rehabilitation from cataract surgery. Cataract surgery is the highest volume surgery in this country with over a million cases being performed annually. No other surgery comes even close to this number of procedures.

Angioplasty and cardiac surgery have made tremendous progress; further refinements will likely occur in the future. Sigmoidoscopy and colonoscopy have gone far in enabling physicians to diagnose neoplasms of the lower intestines. CAT scans and MRIs are almost routine now. Many kinds of lasers (argon, krypton, yag and excimer) are used for different purposes and in different specialties. Isotopes to identify various diseases are now readily available.

Modern medicine has had a significant effect on life expectancy. In 1910, life expectancy was 47 years; by 1979, it had risen to 72 years.

While the next century will usher in a new era of medicine that may dwarf present day accomplishments, there is one area that must remain important; that is, the priority of good doctor-patient relationships. Although surveys still show that most patients are satisfied with their personal physician, the polls are beginning to show a significant communication gap. In a 1991 AMA survey, many consumers agreed with statements that were critical of American physicians — only 43 percent felt that doctors usually explain things well to their patients, and only 31 percent said that most doctors spend enough time with their patients. On top of that, 69 percent agreed with the statement, "People are beginning to lose faith in their doctors." We cannot ever lose sight of our ultimate reason for being a physician: — the patient is our primary concern.

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OBITUARY

James Edward Marvil MD **March 2, 1904 - January 23, 1996**

James Edward Marvil MD died of natural causes on Tuesday, January 23, 1996, in Lewes, Delaware. He was 91 years old.

His death brought to an end a distinguished career in medicine and leadership of an intense period of historic preservation in Lewes.

The son of a house mover, Dr. Marvil was born March 2, 1904, in Laurel, Delaware, and had two brothers and two sisters. He graduated from Laurel High School in 1922, the University of Delaware in 1926 and Jefferson Medical School in 1930. As a medical student in 1929, he first came to Lewes where he met his first wife, Comfort Ingram Marvil.

Dr. Marvil began his medical practice as a general practitioner in Laurel and developed an interest in ophthalmology and ear, nose and throat. That interest intensified during a year in Vienna, Austria, in 1937 before he returned to Laurel to work in those fields, which he continued in until his retirement in 1982.

Dr. Marvil started his own hospital in Laurel, where he did tonsillectomies and started a part-time practice in Lewes in the late 1940s. (As one of the founders of Laurel Lions Club, Dr. Marvil was at the center of the Club's first community project, which was to purchase an ambulance.) He moved his

practice to Lewes, full time, in about 1966.

A staff member of Beebe Medical Center for more than 50 years, Dr. Marvil was a past president of the staff there as well as a past president of the Sussex County Medical Society and the Medical Society of Delaware. He was also on the staff of Nanticoke Memorial Hospital from 1952 until 1970. He served as a member of the Board of Medical Practice and chaired a committee to have a medical school in Delaware. That committee was responsible for legislative action that guarantees placement for 20 Delaware students each year at Jefferson Medical School.

In addition to maintaining a vigorous medical practice, Dr. Marvil accomplished much more in his life. At the beginning of World War II, he closed his medical office and volunteered for service in the U.S. Army. He served as a physician in the Aleutian and European theaters in field and evacuation

hospitals. By the time he left the Army in 1945, he had achieved the rank of Lt. Colonel.

From 1934 to 1990, Dr. Marvil served on the board of directors for Sussex Trust Company and served as president of the bank shortly after the death of Ford Warrington.

Dr. Marvil pursued recreational interests as avidly as he pursued his professional interests. He was an ardent quail hunter and especially enjoyed watching the dogs work. In



his early married life, Dr. Marvil rode horses that he stabled in a barn behind his Laurel home. He often used a horse and buggy or horse-drawn sleigh to make house calls.

Dr. Marvil inherited an interest in ships from his maternal grandfather, collected many ship models and paintings, and wrote books about the Bethel, Delaware-built sailing rams designed for the Chesapeake and Delaware Canal and about the river pilots of Delaware Bay.

As one of the founders of the Lewes Historical Society, Dr. Marvil left a strong mark on Lewes. He was president of the Society until 1980 and then continued as chairman of the board until his death. Under Dr. Marvil's leadership, Lewes Historical Society established the historic complex at Third and Shipcarpenter streets and preserved and restored a variety of 17th, 18th, and 19th century buildings. He and his first wife restored a 1764 house on the canal in Lewes and filled it over the years with antiques they collected along the way.

Dr. James Beebe, a close friend of Dr. Marvil, said he was a kind and gentle person, "a true gentleman."

Dr. Marvil is survived by his second wife, Catherine, a daughter, Trennie, a granddaughter and two great-grandchildren.

Remembered by:

Trennie Elliot

James Beebe MD

Dennis Forney, *Cape Gazette*

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Medicare HMOs: Part of the Solution or Part of the Problem in the Struggle for Cost Containment?

Sara F. Sutherland MD
Robert E. O'Connor MD

Introduction

With Medicare reform at the top of the Republican agenda, many are searching for the optimal way to reduce the amount paid by the federal government for the program. Estimates looking at the current model expect the part A trust fund to run out of money by 2002.¹ A managed care model for Medicare has received close attention from the Republican lawmakers as a potential method of cost containment. This form of care for the elderly has been available for the past 13 years. According to an October 19, 1995, *Wall Street Journal* article, currently 10 percent of Medicare's 37 million beneficiaries are enrolled in some sort of Health Maintenance Organization (HMO), having grown 25 percent last year.² The questions posed by this form of medical coverage relate to concerns over the validity of cost savings and the adequacy of coverage provided. Marketing tactics used to attract new Medicare enrollees have been subject to scrutiny regarding false claims and "skimming" practices designed to attract the most healthy patients.

Historical Perspective:

Why We Are Where We Are

HMOs began to care for Medicare patients in 1982 with the enactment of the Tax Equity and Fiscal Responsibility Act (TEFRA). This act established capitation payments to HMOs and Competitive Medical Plans (CMPs) for Medicare beneficiaries be set at 95 percent of

what an enrollee would have cost Medicare had they remained in the fee-for-service (FFS) medical care system.³ These rates were set according to the "adjusted average per capita cost" (AAPCC) which are calculated to be county specific and adjusted to reflect age, sex and other risk factors.³ This fixed formula yields rates that vary widely across the country, ranging from \$8,086 per year per beneficiary in Staten Island, NY, to \$2,459 in Costilla County, CO.⁴

Soon after the TEFRA program began, it was evident that there was a favorable selection bias for participating HMOs.^{3,5} The AAPCC rate disparities encouraged the establishment of Medicare HMOs in areas where Medicare pays the highest rates.^{4,7} Outright "skimming," which means that healthy patients are enrolled, while sicker patients are excluded, is prohibited by TEFRA.⁵

A study to determine if there were specific marketing elements of a Medicare HMO's campaign responsible for the selection bias failed to discern any significant marketing decision variable. The study also found no suggestion for differential market segment targeting by the HMOs.⁵ If HMO marketing was not the reason for the favorable selection bias, what was?

The conclusion of the study was that self-selection was a major factor in selection bias.⁵ Sick patients were less likely to change physicians and join an HMO when compared to healthy patients.⁴ As a result, Medicare HMOs get the benefit of high rates, which are calculated based on an average of the

Drs. Sutherland and O'Connor practice in the Department of Emergency Medicine, Medical Center of Delaware.

spectrum of patients in the area, but typically care for only the healthiest patients. The gap between AAPCC rate and the cost of the healthy enrollee goes directly to the bottom line. To try to counteract the presumed marketing bias towards healthy patients, the Health Care Financing Administration (HCFA) conducted a three-year study evaluating whether an independent HMO broker could reduce the enrollment bias and better serve the Medicare population in Portland, Oregon.³ The results again supported the self-selection conclusion, as there was no reduction of the selection bias with the broker.

Pursuing the Elusive Benchmark

Given that Medicare HMOs cater to the healthier members of the Medicare population, do these patients receive better care? The only way that the HMOs will be profitable is to assure that they pay health care providers less than the government pays the HMO. In the best of all worlds, this encourages vertical integration, coordination of services and cost reduction.⁶ In the worst of all worlds, this encourages limitation of services and fraud. The HMOs that exist in competitive (high AAPCC rated) markets provide comprehensive services with many additional services.⁷ The government reimbursement can often exceed corporate HMO rates, for example, in Dade Co., Florida, a Medicare HMO receives \$616 per month per senior compared to \$80 to \$110 per month for a corporate employee. Granted seniors are more expensive than the younger workforce.⁷ Perhaps the 700 percent premium paid in Dade is a bit more than is necessary.

Are the elderly able to adequately assess the quality of the HMOs that market their services directly to them? Most Medicare beneficiaries enrolled in HMOs join on an individual basis, instead of through a group enrollment process typical of an HMO's commercial lines of business.⁵ Marketing tactics employed to enroll seniors include direct mailing, community programs at senior centers and television advertisements. The benefits provided by the Medicare HMO will vary widely, with areas of high competition corresponding to areas where the TEFRA formula

reimburses well.² Some plans will indeed expand the benefits normally provided under Medicare, others will not. Most have a specific group of primary care physicians who cover the Medicare HMO practice and often a senior will have to change doctors with enrollment. Coverage is typically limited to the enrollee area, seniors who travel or have two homes will have coverage difficulties. Unlike corporate-sponsored plans however, Medicare beneficiaries can disenroll with just 30 days' notice from any of the Medicare HMOs. They will then be able to resume "normal" Medicare service. One potential problem that could occur with the return to traditional Medicare benefits relates to Medigap insurance. Seniors who decide to drop their Medigap insurance when they join the HMO may have difficulty obtaining it again should they decide to leave the HMO.²

Conclusion

The correct answer for salvage of the Medicare program while maintaining acceptable medical care is clearly not available today. Managed care programs for seniors have been an option in the last decade and plans are expanding rapidly into previously untapped areas. Some programs can indeed provide a multiplicity of services and thereby truly integrate and improve existing care plans. Others have less clear cut advantages. For any senior contemplating the options available for medical care under Medicare, HMOs and Medigap type instruments, the most salient advice is "buyer beware." A complete understanding of the options gained and lost by changing medical insurance coverage is essential.

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Primary Care in the Emergency Room

Ben Corballis MD

Dr. Bob Frelick, in an otherwise excellent article, has chosen to perpetuate certain myths about care given in the Emergency Department. These myths are not only inaccurate but appear to be deliberately distorted to prove a point. He states, "Emergency rooms with full-time specialized physicians provided primary care for the underinsured. Simple head colds could easily cost 10 times an office charge." He then suggests that to cover these costs, health insurance rates went up and more and more people joined the ranks of the uninsured. Surely he can not believe these statements. Some very simple research on his part would have arrived at the truth.

At the Medical Center of Delaware Emergency Department (which clearly has the largest share of uninsured and underinsured patients), since the advent of "level-of-care billing" and the provision of "fast track" services in 1976, the financial problem stated by Dr. Frelick has not existed. The physician charge for a patient with a "head cold" back in 1976 was in the neighborhood of \$15.00 and has risen to a maximum level at the present time of \$37.00. The hospital charge at the present time is \$65.50. This patient with a head cold would face a maximum charge of just over \$102.50. Is he telling us that we are at present in an era where an office charge is \$10? I would also like to point out that the underinsured of whom he speaks are mainly

Medicaid patients. In the early years (up to about four years ago) the physician's compensation for these visits was \$12.72. This was not only the compensation for a "head cold" but for any code submitted up to and including cardiac arrest or trauma codes. \$12.72! The hospital reimbursement was similarly controlled and very low. The present reimbursement for the physicians is \$31.00. The present hospital reimbursement (at 71 percent) is \$46.50. The total cost is thus \$77.50. What is an office charge at present?

These patients, since 1976, have been treated in "fast tracks." A fast track is an area specifically designed for the low acuity patient where the physicians, although initially emergency physicians, are now generally Board Certified family practitioners. It is also true that for the last five years at the Medical Center we have made very good use of physician assistants to provide these services under direct supervision of the emergency physicians, which has the net effect of lowering the cost of providing these services. I believe Dr. Frelick must look elsewhere for proof that allowing these patients to use the Emergency Department is pauperizing the medical care system.

I would also suggest that Dr. Frelick should look very carefully at the availability of primary care physicians in the city of Wilmington. After all, it is in the city of Wilmington that the vast majority of these uninsured patients in northern Delaware live. For instance, in family practice my count (an approximate number) lists 22 practitioners. Over half of these are placed in only

Dr. Corballis is the president of Doctors for Emergency Service (DFES).

three locations: two hospitals and one large, single specialty practice. There are fewer internists and pediatricians than family practitioners. Southbridge and Henrietta Johnson and the A.I. duPont pediatric clinics while scattered throughout the city, do not even come close to meeting the needs and are open only for limited hours. Vast stretches of our city have no easily reached primary care practitioners available to these patients.

If Dr. Frelick would think this through, he would realize that Emergency Departments are and have been the safety net for the citizens of New Castle County. The solution to the money problems of health care in Delaware does not lie in shredding the safety net nor in preventing the most vulnerable and least able to cope patients in our commu-

nity from using the safety net. Maybe in a generation or two there will be enough primary care physicians established in the city to make care available to those in need, but in the meantime we in emergency medicine are neither the cause of the problem nor is the idea of depriving our patients of care part of the solution. In fact, if health planners would consult with us and look at it objectively, we might very well be able to be part of the solution by becoming the after hours primary care physicians to those people who cannot seek their health care during regular business hours due to many socio-economic factors and/or for those who out of ignorance or other pressing factors (alcoholism, drug addiction, etc.) cannot take advantage of a "normal" health care system.

Dr. Frelick Responds

Robert Frelick MD

This letter to the Editor of the *Delaware Medical Journal* is in response to Dr. Ben Corballis's concern about the examples used in my recent article "Why Health Care Is Faltering in Delaware."

Dr. Corballis was upset because the article's mention of the high costs of emergency room primary care did not mention the fee reductions offered for primary care emergency services to un- and underinsured Delawareans. I had used the high costs of emergency room care as one example of increasing health care costs which have made it impossible for many Delawareans to afford health insurance. I agree that the "fast track" system of primary care in the Medical Center's Emergency Department is effective and it provides a needed service when other sources of primary care are not available. My article addressed health care problems in the entire state — not just New Castle County. Impaired access to primary care for the needy may be more crucial in Kent and Sussex Counties than in Northern Delaware.

The medical literature is replete with references to excessive costs for emergency room primary care, without criticizing the ratio-

nale for such charges. Emergency room primary care often costs more than the initial fee because of the extra laboratory and support services often requested by emergency room physicians for patients who are not known to them. Thus, the costs of a single visit usually exceed the charges for a private office visit of a familiar patient. The loss of continuity of care is difficult for emergency room physicians, but amply justifies the extra studies and charges. It should be far more cost effective if access to primary care, except in case of an emergency, were assured to a personal primary care physician.

The Emergency Department of the Medical Center of Delaware should be commended for the excellent way it supplements private primary care for the un- and underinsured, and for having such services available at all times for everyone. If Delaware's Medicaid managed care program reduces the need for Emergency Department services, will the Medical Center be able to continue its "fast track physicians assistant" services which provide a valuable "safety net?"

Dr. Corballis is correctly asking health planners to work with emergency room

physicians to assure that those services will be part of the solution for those who find it hard to locate a personal physician or to comply with the available hours for office primary care.

I hope that the day will come when emer-

gency physicians can electronically access the primary care office records of patients no matter when and under what circumstances such services are requested to help overcome the handicap of loss of continuity of care either for an emergency or for primary care.

Bacterial Infections and Deep Implants

G. Dean MacEwen MD

Some months ago you had an article in the *Delaware Medical Journal* suggesting that there was no correlation between bacterial infections and deep implants. I think that is open to question. This paper from Dr. Hungerford (see abstract) certainly questions it. You can call him if you want and get more details. Also, the new professor of orthopaedics at the University of Pennsylvania thinks there is a correlation and at least should be covered up to two years after the implant has been done. I wonder if something more should be done rather than leaving a flatfooted statement that nothing should be done as was presented in the *Journal* (abstract)

Paper No. 491

Arthroplasty Infections Associated With Dental Procedures

Barry Waldman MD, Baltimore, MD

Michael A. Mont MD, Baltimore, MD

David S. Hungerford MD, Baltimore, MD

"To better define the risk of infection associated with dental surgery the authors retrospectively reviewed 3,029 patients treated with total hip or knee arthroplasty between 1980 and 1994. One hundred thirteen late infections of prosthetic joints were identified. Of these, five infections were strongly associated with a dental procedure both temporally and bacteriologically. Based on these data, the questions of whether antibiotic prophylaxis should be extended to all total joint arthroplasty patients should be considered."

Low Back Pain

Ali Kalamchi MD

I received the March issue of the *Delaware Medical Journal* and reviewed the content with special interest in your coverage of low back pain. The articles you have reprinted are certainly the extreme in trying to promote chiropractic treatments for back pain. I am disappointed to see that you have not contacted nor have had any articles from the orthopedic or neurosurgical literatures to deal with back pain. The chiropractors have a very limited role in managing acute low back pain with conservative therapy program. Beyond that, their approach to back pain and other problems are really not scientific nor

worthy even of getting into an argument about their value.

I voice my objection and sentiment to the way the *Journal* and the Board of Editors have dealt with the issue of back pain without even consulting any of the spine surgeons and rehabilitation physicians that deal with this issue in Delaware on a regular basis. Certainly, I hope in the future such a complex issue will have the input of the mainstream physicians' opinions.

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IN BRIEF

A Reminder to Hospital Workers

Health care workers born after 1957 are among the adults most at risk of contracting measles.

According to the Centers for Disease Control and Prevention (CDC), measles can be transmitted easily in the hospital setting. Not only do susceptible health care workers come in contact with patients who are infected with measles, but staff who are infected may transmit the highly contagious disease to other patients, especially those with compromised immune systems, and other hospital personnel.

The CDC has issued a statement encouraging everyone born after 1957 to receive a second dose of measles vaccine. In addition, the Advisory Committee on Immunization Practices (ACIP) recommends, as a condition of employment, that all health care workers born after January 1, 1957 — with the exception of those who have documented evidence of immunity — receive a second dose of measles-containing vaccine.

The recommended second dose is intended as a safety net to protect the estimated 5 percent of individuals who fail to respond after the first dose and those who have not been vaccinated at all.

CDC data issued earlier this year shows that measles has shifted from being a disease of preschool-aged children to one of school-aged and post-school-aged Americans. The ACIP encourages two doses of the measles vaccine for all individuals born after January 1, 1957.

Citing statistics from the CDC, for the years 1989-1991, 668 health-care workers contracted the disease. Of that number, 187 were hospitalized and three died. The statistics further show that 90 percent of these health-care workers contracted the disease from patients, 10 percent from co-workers.

First Multicenter Clinical Trial in Post-Polio Syndrome

Focuses on Oral Pyridostigmine

Six major medical centers in the United States and Canada have begun recruiting patients in the first multicenter clinical trial of a potential medical treatment for post-poliomyelitis syndrome (PPS). PPS is a progressive neuromuscular syndrome which is estimated to affect approximately 50 percent of the 640,000 polio survivors in the United States who recovered from paralytic disease contracted decades earlier, prior to the advent of polio vaccines.

Currently, there is no primary treatment for this syndrome, characterized by the appearance of new pain, fatigue, and muscle weakness an average of 35 years after recovering from paralytic polio. Medication can be prescribed for pain. Weakness may require orthotic devices, such as braces, or assistive devices, including wheelchairs, crutches, or motorized scooters. Exercise has been found to increase strength in some patients. However, fatigue, a major symptom of PPS, and probably the most disabling, will be the focal point of this trial.

33rd Annual Infectious Disease Symposium

From May 7 to 9, 1996, the Infectious Disease Symposium will be presented at the Delaware Academy of Medicine, 1925 Lovering Avenue, Wilmington, Delaware. For more information contact William J. Holloway MD, Director, Infectious Disease Research Laboratory, Medical Center of Delaware, 501 West 14th Street, Wilmington, Delaware 19899. Or call (302) 428-2744.

VNA Delaware Achieves Joint Commission Accreditation

The Visiting Nurse Association (VNA Delaware) is pleased to announce that it has been awarded accreditation from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

VNA Delaware, a comprehensive home health care provider serving Delaware since 1922, voluntarily sought JCAHO accreditation to demonstrate its commitment to delivering high-quality health care. Formed in 1951, the Joint Commission is dedicated to improving the quality of the nation's health care through such voluntary accreditation.

In December 1995 VNA Delaware was evaluated by a JCAHO surveyor experienced in the delivery of home care services and demonstrated compliance with the Joint Commission's set of national standards.

Richard Cherrin, president of VNA Delaware states, "Receiving JCAHO accreditation is an important milestone in our ongoing efforts to provide a high quality home health care delivery system."

A.I. duPont Institute Department of Pediatrics Appoints Vice-Chairman for Research

The Alfred I. duPont Institute has appointed Roy Proujansky MD as vice-chairman for Research in the Department of Pediatrics. Dr. Proujansky serves as chief of Gastroenterology, and previously served as a Pediatric Gastroenterologist and assistant professor of Pediatrics at the Children's Hospital of Pittsburgh.

Dr. Proujansky has distinguished himself as a superlative clinician and an outstanding clinical and basic science researcher. As vice-chairman for Research, Dr. Proujansky will assist in developing the ongoing research efforts in the Department of Pediatrics.



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MSD MONTHLY ACTIVITIES

Working for You: March 1996

Leadership Activities

- Dr. Charles Konigsberg represented the Society and the Division of Public Health at the first annual Medicine/Public Health Initiative in Chicago.
- Mr. Meister represented the Society at the annual meeting of the Coordinating Council for Children with Disabilities.
- Dr. Paul Howard, Dr. Carol Tavani and Mr. Meister attended the AMA National Leadership Conference in Washington D.C.
- Mr. Battaglia and Mr. Meister met with Stevens Remillard of BCBSD to discuss plans for notifying physicians regarding intent to amend the BCBSD Participating Physician Agreement for participation in the Diamond State Health Plan.
- Mrs. Dieffenbach met with Barbara Barnes of the Hotel duPont to begin planning the 1996 Annual Meeting.
- Dr. Collier, Mark Meister, Beverly Dieffenbach and Heidi Norman met to prepare the application for reaccreditation of the Society's ACCME continuing medical education program.
- Representatives of the Society and the Delaware chapters of ACOG and AAP met to discuss 48 hour maternity legislation with Senator Joe Biden.

Physicians' Advocate Program Activities

- Held a Medicaid Managed Care program with panel participants — Diamond State Health Plan carriers, State Medicaid Administrator Kay Holmes and EDS Specialist Bonnie Coleman.
- Plans were finalized for the Second Annual EDI Conference to be held on May 15, 1996.
- Presented a resident workshop entitled "I Didn't Know" Won't Save You from an Audit" was held. Attendees learned the importance of E&M guidelines, documentation guidelines, and received information on evaluating the HCFA form and ICD-9 and CPT coding highlights.
- Provided consulting regarding accounts receivable and practice management issues, and starting up a practice.

- Attended the monthly DMGMA meeting and the quarterly meeting of the Medicare Beneficiary Liaison Council, where Medicare/managed care and how it is affecting physicians and Medicare beneficiaries was addressed.

Continuing Medical Education Activities

- Sponsored 22 educational activities for Category 1 credit.

Credentials Verification Organization (CVO)

- Program Manager Gina Bodycot RN, BSN was hired and joined MSD staff on March 18, 1996.
- CVO workplan developed and implementation begun.
- Attended American Association of Medical Society Executives, CVO Special Interest Group Quarterly Meeting in Washington D.C.
- Analyzed data from country-wide survey of other medical society's CVOs regarding: software, start-up, etc.
- Began development of MSD's CVO contract for use with various entities including but not limited to managed care organizations and hospitals.

Other Activities

- The following physicians spoke at the 1996 Doctor/Lawyer Partnership Against Drug Abuse, on March 5-11, 1996 at area schools: Charles Allen MD, Ben Corballis MD, V. Terrell Davis MD, Joseph E. DeLaurentis MD, Marvin Dorph MD, George Eriksen MD, Robert Frelick MD, Albert Gelb MD, Robison D. Harley MD, PhD, Calvin Hearne MD, William Holloway MD, William Lloyd MD, E. Wayne Martz MD, Peter Mette MD, Allston Morris MD, Jorge A. Pereira-Ogan MD, David Platt MD, Charles F. Richards MD, William Shellenberger MD, Craig Sternberg MD, John B. Townsend III, MD, Dene T. Walters MD.
- The following physicians served as "Doctor of the Day" at Legislative Hall in the month of March: Martin Begley MD, Nicholas Biasotto DO, William H. Duncan MD, Lennart Fagraeus MD PhD, Mark A. Glassner MD, Edward F. Gliwa MPH MD, Harry A. Lehman III MD, Stephen R. Permut MD.

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Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting.

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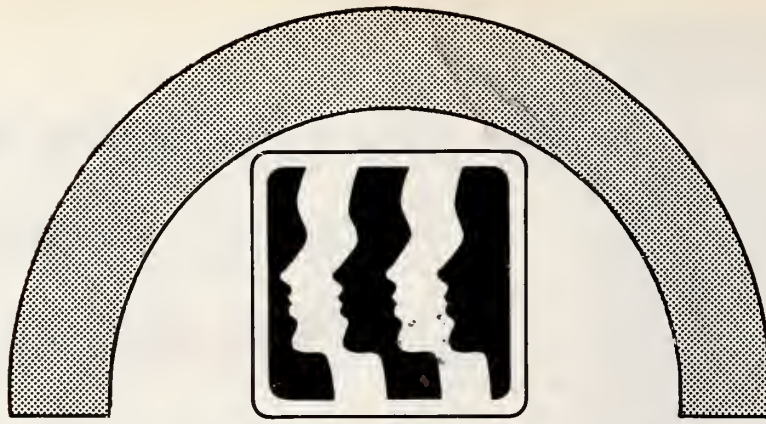
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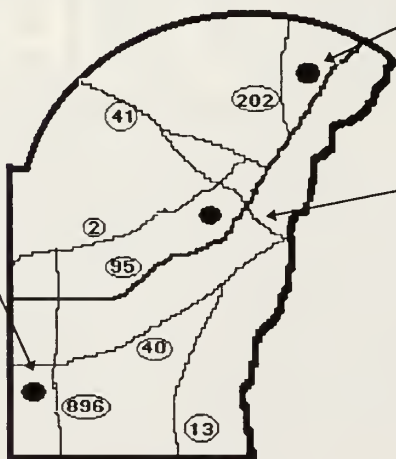
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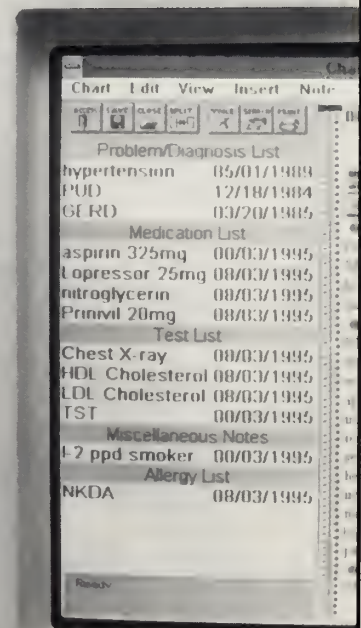
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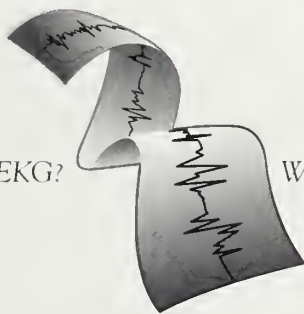


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The World Around Us

In June 1992, I was introduced, in person, to the AMA — first as a Hospital Medical Staff Section Delegate from the Medical Center, and six months later (and at every meeting since), representing the Medical Society as an Alternate Delegate as well — and this June, as President. The House of Delegates is an awe-inspiring experience, and an educational one as well. It represents the inner workings of organized medicine, and much like a visit to a legislature in session, demonstrates how that business is conducted.

Even more exciting is actual participation in the formation of the organization's policy structure. I will never forget the time my testimony eventuated in the adoption of a policy regarding government regulation of certain medications. It demonstrated that the system actually works, and that one small voice can change its course.

Over a two-week period in late April and early May, I was privileged to represent Delaware at the annual meetings of some of our neighboring states. Although much smaller than the national meeting, those of our neighbors are bigger, slicker, and much more formally organized than is ours, and such comparison is inevitable. However, I thought you would find interesting a peek at how their agendas compare with our own.

Bigger states, with much larger physician populations, demonstrate considerable vying and competition for council membership, seats on the Board of Trustees, and delegate and alternate delegate positions, not only to the

AMA, but from the various counties to the State House of Delegates as well. Representation in general is a much greater issue. Beyond those issues which are a function of size, however, the differences begin to diminish. A sample of the topics addressed were as follows.

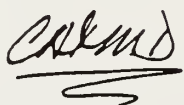
Centralization of physician credentials (a major current undertaking of our Medical Society) was discussed, as was the problem of overwhelming paperwork. Mandatory electronic billing was another item. Managed care issues largely dominated some of the reference committees, with gag rules, authorizations and denials, deselection of physicians from panels, hold harmless clauses, and solicitation of Medicare beneficiaries among them. The problem of uncompensated care looms large everywhere. The Patient Protection Act, fairness to patients, AIDS testing, the tobacco industry, cancer screening, and guardianship procedures were major topics, as were graduate medical education and supply of vs. need for physicians. CPT coding issues were ubiquitous.

If this sounds all too familiar, it is because the problems and issues are similar, if not identical. I felt a certain sense of comfort, as I listened to the initiatives being undertaken elsewhere, even in places with resources much more grand than our own, in that our own initiatives are comparable, and every bit as current.

The import of this in my mind, aside from education and broadening of one's horizons, is

that due to our geographic and demographic relationships and degree in overlap of our patient populations, a significant similarity in standards of care exists, such that extrapolation of decisions and policies carries great validity; thus what transpires in our neighboring states has tremendous impact upon us.

I am grateful to my hosts in these sojourns, who could not have been more gracious, but who, moreover, were quite candid and forthright about their own problems and struggles both with external forces and intramurally, and about their own ideas and efforts to solve them. They allowed me this insider's view of issues very pertinent and related to our own. We can only benefit from knowing the world around us, and I thank them for this unique opportunity.



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Charcot-Marie-Tooth Disease Associated With Hip Dysplasia: A Case Report

Tony R. Cucuzzella MD
James T. Guille BA
G. Dean MacEwen MD

Abstract

A 31-year-old woman with a known history of hip dysplasia was found to have Charcot-Marie-Tooth disease following abnormal conduction studies done at the time of surgery. Physical examination in this patient was otherwise normal, and the diagnosis of Charcot-Marie-Tooth disease had not been previously considered. This report demonstrates the importance of keeping in mind the association between hip dysplasia and Charcot-Marie-Tooth disease.

Introduction

Hereditary motor and sensory neuropathy (HMSN) type I, often referred to as Charcot-Marie-Tooth disease or peroneal muscle atrophy, classically is characterized by distal muscle weakness, high-arched feet with hammer toes, markedly slow motor nerve conduction velocities, hypoactive or absent deep tendon reflexes, and mild to moderate loss of sensation. The onset of weakness, which usually presents as a foot drop, is often noted in the second decade of life. Generally, the condition is slowly progressive with prolonged plateaus. Some carriers of this autosomal dominant genetic mutation may be essentially asymptomatic, others will only have hyporeflexia, but all will demonstrate delayed motor nerve conduction velocities.¹

In 1985, Kumar et al. presented a short report suggesting an association between hip dysplasia in children and Charcot-Marie-Tooth disease.² These authors recommended that children with Charcot-Marie-Tooth disease have their hips examined regularly, and that children with hip dysplasia should have

neurological and electrophysiological testing to exclude the diagnosis of Charcot-Marie-Tooth disease if a neurological condition is suspected. The following case report demonstrates the importance of these recommendations.

Case Report

In May 1976, the patient (at age 14) underwent bilateral femoral osteotomies for internal femoral torsion. The preoperative radiographs of the pelvis at that time revealed irregular ossification of the lateral edges of the acetabulae. On further examination, her hips were believed to be slightly subluxated with increased coxa valga and femoral anteversion.

Postoperatively, the patient did well with only an occasional complaint of mild pain in the ensuing years. She began to experience increased bilateral hip pain in 1981. Radiographs taken in June 1982 revealed bilateral acetabular dysplasia. Due to her painful hip disease, the patient underwent bilateral Chiari osteotomies in January 1983.

The patient did well in the ensuing years until 1990, when she began to complain of hip pain, greater on the right, after the birth of her first child. The pain resolved to some extent one year prior to her presentation. At this time, she began to have steadily increasing hip pain, again following the birth of a child, her second. Radiographs taken in May 1993 revealed bilateral deformation of the femoral heads and post-surgical changes from the osteotomies. In June 1993, bilateral hip arthrograms and a right hip arthroscopy were done, the latter of which revealed an anterior

bony prominence of the right acetabulum with associated irritation of the femoral head anteriorly.

In July 1993, the patient, now age 31 years, underwent excision of the anterior prominence (osteophytes) and an acetabuloplasty of the right hip. Preoperatively, the patient had a routine evoked potential performed, which revealed a markedly prolonged latency value from both ankles and the right wrist; the responses were very small in size. In view of these findings, a nerve conduction study was done. A directed physical examination done prior to the study revealed normal lower-extremity strength, including ankle dorsiflexion and flexion and extension of the toes. There were no deformities noted in the feet or toes. The patient did, however, have decreased vibratory sensation and absent deep tendon reflexes. The gait was normal. The conduction studies revealed that the right peroneal nerve motor response had a prolonged distal latency of 9.3 ms (normal, <6.2 ms) and a markedly slowed conduction velocity of 20 m/sec (normal >40 m/sec). The right median sensory response was absent at the wrist. The impression in this clinical setting was that the findings were consistent with Charcot-Marie-Tooth disease (HMSN type I).

On further questioning, the patient stated that for several years she has noted that her father's feet slap against the floor when he walks. The patient did not know of any other symptoms of lower extremity weakness in the family. She currently plans to arrange for nerve conduction studies for the rest of her family.

Discussion

The familial neuropathy known as Charcot-Marie-Tooth disease, or hereditary motor sensory neuropathy type I, was first described in 1886 independently by Charcot and Marie in France, and Tooth in England. Over the years, different degrees of symptomatology, different patterns of inheritance, and an association with different autosomal dominant disorders (such as neurofibromatosis and myotonic dystrophy) have been described. Dyck and Lambert have shown that some hereditary neuropathies are primarily motor, whereas others are primarily sensory. They referred to the former group as HMSN and

the latter group as HSN. From here, they used clinical, genetic, pathologic, and electrophysiologic criteria to subdivide these two groups into subcategories. The term Charcot-Marie-Tooth disease is deeply rooted in the literature and usually refers to the constellations of findings listed as HMSN type I. This is the most common form of hereditary neuropathy.¹

The typical characteristics of HMSN type I include distal muscle weakness, *pes cavus* deformity (high-arched feet) with hammer toes, marked slowing of motor nerve conduction velocities, hypertrophic ("onion bulb") changes on nerve biopsy, mild to moderate sensory loss, and hypoactive or absent deep tendon reflexes. The onset of weakness is usually manifested as a foot-drop, often in the second decade of life. The condition usually progresses quite slowly with prolonged plateaus. Severe disability is uncommon, although many patients eventually require ankle bracing or triple arthrodesis. Some carriers of the autosomal dominant gene may be essentially asymptomatic, although most will have hypoactive deep tendon reflexes and all will have delayed motor nerve conduction velocities to less than half of normal values. This is due to the repetitive myelination and demyelination of the peripheral nerves. Regardless of the extent of symptomatology, it is believed that HMSN type I does not shorten the patient's life span.

In 1985, Kumar et al. published a report of five patients that suggested an association between hip dysplasia and Charcot-Marie-Tooth disease.² The patients were between 8 and 15 years old and from three families, and had presented for minimally symptomatic hip dysplasia (two were completely asymptomatic and were diagnosed radiographically). Further examination revealed that all of these children had clinical and electrophysiological findings consistent with HMSN. Four patients had HMSN type I, and one had HMSN type II (a milder form than type I with only mild slowing of the motor nerve conduction velocities). It was concluded that a multicenter study should be performed to determine the incidence of hip dysplasia associated with Charcot-Marie-Tooth disease. Further recommendations were that all patients with HMSN should have their hips examined regu-

larly, and that patients presenting with primary hip dysplasia should have a careful neurological and electrophysiological screen to exclude the diagnosis of HMSN if a neurological condition is suspected.

In 1994, Walker et al. reported the results of a multicenter study.³ Of 100 patients with the electrophysiologically proven diagnosis of Charcot-Marie-Tooth disease, 74 patients had adequate hip radiographs to review. Of these 74 patients, only six had evidence of hip dysplasia for a prevalence of 8.1 percent. Twenty-one of the patients had minor abnormalities in 35 hips, such as an increased neck-shaft angle of the femur. These researchers also noted that patients with HMSN type I had more hip dysplasia, and that a preponderance of patients were female.

Pailthorpe and Benson reported on four patients with hip dysplasia, from a series of 44 patients with HMSN.⁴ They believe that failure of initial treatment in some neonatal hips may be attributed to undiagnosed HMSN.

In our patient, following the recommendations of Kumar et al. led to the diagnosis of HMSN type I. It should be noted that this patient could also fit into the description of X-linked HMSN. In these cases, patients who inherit the affected X chromosome may mimic typical Charcot-Marie-Tooth disease. Daughters inheriting the affected X chromosome are usually minimally affected, as in the case of our patient. This is assumed to represent X-linked dominant inheritance. Regardless, a relatively simple diagnostic study led to the diagnosis of HMSN in our patient. The observation by our patient that her father's feet have been slapping the floor in recent years raises strong suspicion that he is the affected parent. Our diagnosis has alerted the patient to have the rest of her family screened for both Charcot-Marie-Tooth disease and hip dysplasia. Screening requires only a physical examination, pelvis radiographs, and nerve conduction velocity tests (a normal motor nerve conduction velocity in two or three nerves essentially eliminates the diagnosis of Charcot-Marie-Tooth disease in children over the age of 10 years).

Each male or female offspring of a person affected with this autosomal dominant gene has a 50 percent chance of inheriting the mu-

tant gene. The great variability of these conditions should be explained to families. In describing an average case, it should be said that mild to moderate weakness of the hands and feet can occur. The weakness is generally first seen as a foot drop. Ankle bracing and corrective foot surgery may be required. It should also be explained that some gene carriers are essentially asymptomatic whereas the more involved cases may eventually require a wheelchair. Life span is not believed to be shortened.

Conclusion

This case report describes a 31-year-old woman with moderate symptomatic hip dysplasia who was diagnosed with HMSN type I. This diagnosis was made following the suggestions of Kumar et al. that patients with hip dysplasia should be screened for HMSN. The incidence of HMSN in patients with hip dysplasia has not yet been determined in a multi-center trial, although the prevalence of hip dysplasia in patients with HMSN was found to be 8.1 percent in a multi-center study conducted by Walker et al. in 1994. To facilitate early detection, all children with HMSN would have their hips examined regularly, with plain radiographs obtained when indicated by physical examination. Similarly, patients presenting with primary hip dysplasia who are suspected of having a neurological condition should have a thorough neurological exam and electrophysiologic screen to exclude the diagnosis of HMSN.

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Hepatitis B Vaccine Completion Among Adolescents

Renee K. Kottenhahn MD
Susan L. Rosenthal PhD
Frank M. Biro MD

Abstract

This study examined hepatitis B vaccination completion among 51 adolescents recruited from a primary care clinic. Seventy-one percent completed the series. Completion was not related to demographic characteristics or attitudinal measures at the first shot. Few opportunities for vaccination were missed. Inconvenience appears to be a factor in failure to complete the series.

Introduction

The development of programs to optimize the delivery of vaccination against hepatitis B (HBV) requires understanding the factors which impact adherence in the dosing protocol. The purpose of this study was to determine if completion of the HBV vaccination series is influenced by adolescent and/or parental attitudes about the vaccine as measured at the time of the first injection. The study follows up on prior research which assessed issues related to the initial acceptance of the vaccine.¹

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Methods

Subjects

Adolescents newly enrolled in a hospital-based adolescent clinic were recruited to participate in a study examining HBV vaccine acceptance.¹ Teens and parents were asked to complete questionnaires with comparable items assessing relevant aspects of decision-making. Parents who accompanied more than one adolescent were asked to reference their answers towards one of the teenagers. The study was approved by the Institutional Review Board.

Measure

A year after the initial recruitment, items from the original questionnaire which were regarded as potentially relevant for completion of the series were analyzed with respect to vaccine completion status at 12 months.¹ Perception of disease severity was measured by asking parents and adolescents to rate on a Likert scale: how sick one *can* get with HBV; how sick one *usually* gets from HBV; and how likely it would be for a person with HBV to get liver cancer or cirrhosis of the liver. Perceived susceptibility was measured by asking them to rate their concern that the disease is "worse" than the shot and their perception of the vaccine's effectiveness. To assess perceived barriers, the subjects were asked about their concern about needing two subsequent injections to complete the HBV vaccination series. Normative beliefs and the importance of the opinion of "others" was assessed by asking both teens and parents about their per-

ceptions of their care provider's opinions, their perceptions of their parent's (or the adolescent's) opinions, whether they believed "everyone" or "all teens" should receive the HBV vaccine, and whether they identified themselves (or their child) as sexually active.

Chart reviews were completed for 48 of the 51 adolescents to determine the number of clinic visits during the study period, the type of visit for the second and third vaccine injection ("shot only" or medical/psychotherapy visit), and the length of time between injections. Three charts were unavailable for review.

The researchers attempted to contact the parents of those adolescents who did not complete the series within one year. These parents were asked if they were aware that their teen had not completed the HBV vaccination series and were asked to respond "true" or "false" to a list of reasons why their teen might be delinquent for vaccination. They were given an opportunity to give other reasons and clarify statements. Of the 12 families, one adolescent received her second shot so recently that she was not yet due for the third, one parent refused to respond, five families had disconnected phones, and another five parents completed the phone questionnaire.

Data analysis was conducted using PC-SAS.² The data were analyzed separately for the adolescents and the parents. The two groups (vaccine "completers" and "noncompleters") were compared for each of the potential predictors using a contingency table or analysis of variance procedure, as appropriate.

Results

Fifty-one adolescents and 42 parents participated in the study as "vaccine acceptors." The adolescents ranged from 11 to 18 years (mean = 14 years). Four teenagers (7.8 percent) received only one injection, 11 (21.6 percent) completed two injections, and 36 (70.6 percent) completed the three-injection series. There were 42 adolescents whose parents completed the questionnaires about their teens (a smaller sample size than the teenagers due to sibling pairs). Only one sibling pair

was discordant for completing the series and there was parent data for both of these girls, as they enrolled in the study on separate dates. The noncompleters represented 12 families.

The mean length of time between the injections was as follows: first to second injection mean was 75 days (SD = 89), second to third injection mean was 201 days (SD = 41), and first to third injection mean was 261 days (SD = 80).

There was no difference between vaccination groups regarding age, gender, and race. There was no difference between the groups for either the adolescents or the parents in any of the attitudinal measures. For the 48 adolescents whose charts were reviewed, the number of clinic visits for purposes other than "shot only" visits ranged from 0 to 14 visits (mean = 1.48). Twenty-three percent of the noncompleters and 60 percent of the completers had visits to the clinic other than "shot only" visits. For the 35 adolescents who completed the HBV series and whose charts were available for review, 16 HBV vaccinations occurred at a visit scheduled for something other than an HBV injection. Two subjects who had not completed the series had an additional visit each without injections, indicating missed opportunities for vaccination.

The five parents who were available for the phone follow-up survey all knew that their adolescent had not completed the series, but indicated their endorsement that their teenager should complete the series. One of the adolescents was living somewhere other than the parent's home, and for the remaining four families, "inconvenience" and scheduling conflicts were identified as the major factors resulting in vaccination delinquency.

Discussion

Once the HBV vaccination series was initiated, the majority of adolescents completed the series, as has been demonstrated in previous studies.³ By assessing the vaccination status of adolescents after one year and comparing responses to questions of health decision-making, our study could not identify any attitudinal differences between

completers and noncompleters. It is possible that responses relevant to vaccination initiation are different than those relevant to vaccination completion.

This study was limited by the small sample size. In addition, the subjects were all drawn from one clinic with a history of high rates of immunization completion, with a mechanism for telephone and written reminders.³ However, the findings have implications for programs designed to improve HBV vaccination.

Inconvenience was a critical reason for noncompletion, and 45 percent of those families who had not completed the series had disconnected phones. For many of these adolescents, completion was facilitated by taking advantage of opportunities for vaccination. Thus, implementing school-based immunization programs where patients and care providers are mutually accessible may be an important strategy to facilitate vaccination. This would eliminate the difficulty described by parents who endorsed having their adolescent vaccinated but found it difficult to coordinate schedules. School-based immunization may also provide a message to parents and teens that *universal* immunization is important. A belief in universal vaccination has been demonstrated to be related to beginning the HBV vaccination series.¹ However, in any setting, health care providers should consider every visit an opportunity to review records and administer appropriate vaccinations, even when seeing adolescents in an emergency room.^{4,5} The care provider should not be concerned about the variance in the timing of

the injections which will result; patients with lapsed immunization for HBV can complete their series regardless of the interval from the last vaccine dose.⁶

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RADIOGRAPH OF THE MONTH

Peter Dross MD
Stephen Ross MD PhD

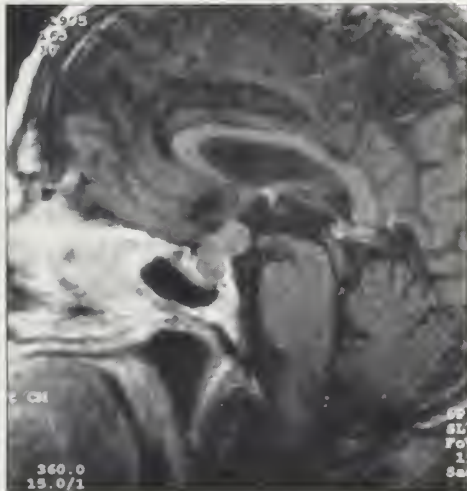


Figure 1. Saggital T1 MRI shows intrasellar enhancing lesion with suprasellar extension

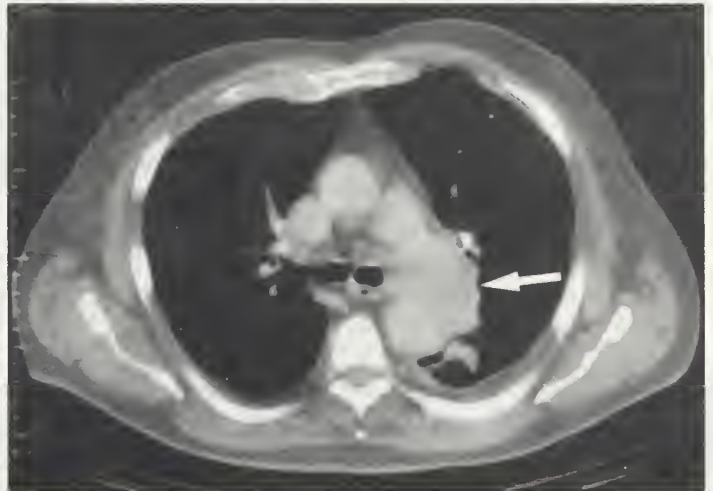


Figure 2. Soft tissue mass measuring 5 cm (arrow) located between left pulmonary artery and descending thoracic artery.

A 77-year-old male smoker presents with a three-week history of dyspnea, chest pain, nausea and vomiting, headache, eye strain and manifestations of the syndrome of inappropriate antidiuretic hormone.

What is your diagnosis?

Diagnosis: Small Cell Lung Carcinoma with Metastasis to the Pituitary

Metastasis to the pituitary gland is an uncommon sequela of any cancer and can masquerade as a primary pituitary tumor.

In this patient a chest radiograph from a previous hospital admission revealed a prominent left hilum. Computed tomography (CT) of the chest confirmed the presence of a left hilar mass with main stem bronchus compression (Figure 2). After initial chemotherapy and radiation treatments, the patient presented to our institution with a plethora of emergent clinical problems, including pneumonia, sepsis, and the syndrome of inappropriate antidiuretic hormone (SIADH) and extraocular nerve palsy. MRI (Figure 1) demonstrated a large homogeneously enhancing pituitary mass with suprasellar extension and optic chiasm compression. Small cell lung cancer metastasis to the pituitary was discovered at biopsy.

The most frequent suprasellar masses include: suprasellar extension of pituitary adenoma, meningioma, craniopharyngioma, hypothalamic/chiasmatic glioma and aneurysm with suprasellar extension of pituitary adenoma being the most common.¹ These five disease processes account for over 75 percent of juxtasellar masses.² Meningitis, granulomatous diseases (e.g., sarcoidosis, tuberculosis) and metastases account for only 20 percent of juxtasellar lesions. Metastatic disease infrequently presents as a suprasellar mass. The pituitary gland is a relatively uncommon site for secondary involvement in patients with disseminated metastatic cancer.³ Overall incidence is reported to range from 3 to 5 percent, with the majority being discovered at autopsy. Central nervous system (CNS) metastases are major complications of malignancies, particularly with lung, breast and hematological cancers.⁴ Of the pituitary metastases, the most commonly involved primaries are breast (53 percent), followed by lung (19 percent), colon (6 per-

cent) and prostate (6 percent).⁵ In lung cancer patients, brain metastases occur with greater frequency in small cell carcinoma than other histological types.⁶ The incidence of brain metastases in patients with small cell lung cancer is 10 percent at the time of initial diagnosis, at least 30 percent over the course of the disease, and 50 percent at autopsy.^{7,8}

CNS metastases in patients with small-cell cancer have been classified into three groups in order of decreasing frequency: intracranial, leptomeningeal and spinal with cerebral metastases being the most common intracranial form.⁶ Leptomeningeal and, in particular, pituitary metastases (both with or without brain involvement) have been reported with increasing frequency in patients with small cell cancer. It has been postulated that the reason for the increasing frequency of lepto-meningeal and pituitary metastases is the association between lengthening survival rates and increasing frequency of CNS metastases.⁴ There are several mechanisms that operate in generating CNS metastases and include hematogenous spread, marrow extension through penetrating vessels, and extension between leptomeningeal and cerebral or spinal sites.⁴ Patients with small cell lung cancer with bone marrow involvement at diagnosis are more likely to develop CNS metastases.

The neurohypophysis (posterior pituitary) has been implicated as the most common intrasellar site of involvement in patients with metastatic pituitary lesions. This propensity for neurohypophyseal involvement in pituitary metastases is an expression of the normal hypothalamic-hypophyseal vascular anatomy.^{3,9} The stalk and posterior lobe receive a direct systemic arterial blood supply through the superior hypophyseal, trabecular and inferior hypophyseal arteries, while the anterior lobe is irrigated principally by portal vessels arising from capillary plexuses in the median eminence, tuber cinereum and lower infundibular stem.⁹ It follows that metastatic disease would be localized to areas that are directly and more richly vascularized with adenohypophyseal involvement a result of direct invasion from the posterior lobe.^{9,10} When metastatic tumor is present in the

Drs. Dross and Ross are Radiologists at the Medical Center of Delaware, Newark, Delaware.

anterior lobe, it is usually associated with a larger posterior lesion from which it has extended.¹⁰

The association of dilutional hyponatremia and small cell lung cancer was first described by Schwartz et al in 1957.¹¹ Small cell carcinoma of the lung has subsequently been shown to produce a variety of peptide hormones, including ADH, ACTH, calcitonin and serotonin.¹² Development of the SIADH in patients with bronchogenic carcinoma appears to be restricted solely to the small cell histologic variant.¹² Small cell carcinoma is now recognized as a very frequent cause of chronic SIADH and accounts for up to 75 percent of tumors associated with the syndrome.¹² Small cell lung cancer, like many other neoplasms, is made up of a heterogeneous cell population with only a fraction of these cells producing ADH.¹³ While the factors involved in ADH production by small cell lung cancer cells are not completely understood, ADH production has been shown to be independent of tumor bulk.

In summary, this report discusses the case of a patient with SIADH and small-cell lung metastases to the pituitary gland. While the most frequent suprasellar masses do not include metastases, it must be recognized as a diagnostic possibility, particularly in patients with a known lung primary and a clinical presentation of headache, extraocular nerve palsy or visual field defects and SIADH.

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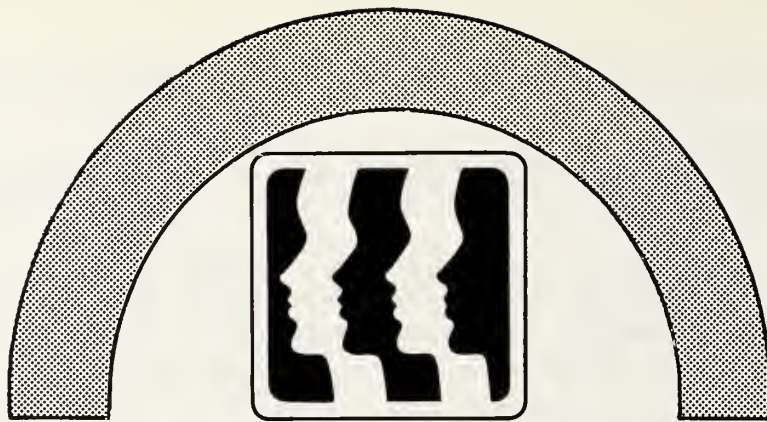
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under substandard coverage or a minimal plan, but will leave this to be done by practitioners who work for free clinics. Into whatever houses I enter, I will go into them for the benefit of the managed care plan, and will abstain from every voluntary suggestion of procedure or practice which might eventuate cost to the plan, and further, from the explaining of a denied procedure to females, or males, to freedmen and slaves. Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men who make medical care decisions for the plan, which ought not to be spoken abroad, I will not divulge as reckoning that all such should be kept secret. While I continue to keep this Oath inviolate, may it be granted to me to enjoy capitation and the practice of Care Allocation, respected by all managed care companies in all time! But should I trespass or violate this Oath, may eternal deselection be my lot!



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The Study of the Federation: Restructuring the AMA

Prerna Mona Khanna MD MPH
Stephen Permut MD JD

It's been a long, tough winter; and now that spring has emerged, the air is full of change and promise.

Guess what? Change is contagious. Even the American Medical Association is catching it.

We're not calling it spring at the AMA, though. We're calling it the Report of the Study of the Federation.

It's the document that was discussed at the AMA's semi-annual meeting in Washington last December and covered pretty extensively in medical publications.

The report proposes several changes in organized medicine to enable our geographical and special-interest societies to work together better and more cohesively, to collectively address marketplace challenges facing the medical profession and to strengthen physician unity and patient advocacy.

Among other recommendations, it specifically asks that the governance of the AMA evolve to mirror the evolution of the medical profession. The report suggests ways to counter the increasing fragmentation of physicians who are joining their specialty societies only by asking these societies to send more representatives to the AMA's policy-making body, the House of Delegates, for better overall physician representation.

The ultimate goal of the whole project is to make the life of the practicing physician who is trying to provide quality patient care a little easier. When the medical profession stands united, it furthers health policy and medical standards.

Dr. Khanna is an internist training in public health at Johns Hopkins University in Baltimore, MD. Dr. Permut is a family physician in Wilmington, DE. They both served on the Consortium of the Study of the Federation, the group charged with developing a future plan for the viability of medical associations.

When it doesn't stand united, it sends mixed messages to the media, the public, and the policy makers. Maybe that was tolerable before, with a stable external environment. But now, industry turbulence is the norm rather than the exception, and the increasing fragmentation of the medical profession is only

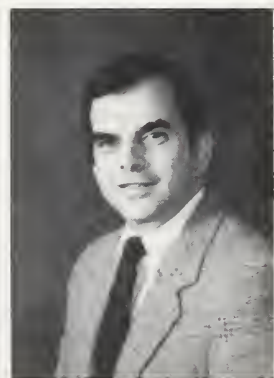
crippling our efforts at addressing the competitive, regulatory, social, technological and economic challenges that are being dished out.

So, we propose the following: each fall, AMA member physicians will pick one specialty society to represent them. After all of the ballots are tabulated, each society will get proportional representation in the AMA House of Delegates based on these votes, in addition to the current AMA representation that they receive through their state societies.

There are other suggested changes, including a better way of involving physicians who may feel disenfranchised by the current configuration of the AMA House, and who are increasingly becoming power-



Dr. Prerna Mona Khanna



Dr. Stephen R. Permut

ful forces in medicine. Just look at a snapshot of contemporary medicine.

Women physicians are increasing in number and clout faster than any other subgroup; international medical graduates currently make up more than 20 percent of all U.S. practitioners; and minority physicians are a substantial number of all U.S. physicians, give or take a few thousand, depending on one's definition. Although we haven't yet determined the exact mechanism for increased involvement by these subgroups, it is intended that they play a greater role in the governance than before. We are hoping that they themselves will fashion proposals of participation for consideration by the AMA House.

There will be no change in representation of state societies.

The recommendation to change the AMA's policy-making body is simply a reflection of the overall shifting perception of increasing importance and value of specialty and special-interest affiliation over affiliation with geographical organizations. If this is the preferred direction of physicians of America, then the AMA should reflect that direction.

Shaping the governance of the AMA to reflect the physician population first took place in 1901 by the McCormack Committee, a group called in to submit recommendations based on that medical system.

At that time, physicians were a more homogeneous bunch — they were almost exclusively born and trained in the U.S.; there was one main divide between the two specialties of general practice and surgery; and there existed one type of practice: solo.

Today, heterogeneity prevails in the physician population. In addition to gender, ethnic and racial diversity, even the kind of medicine and types of practice delivery have changed. Numerous primary care, nonprimary care, subspecialties and super-specialties exist to care for the most elusive of illnesses; and multiple variations on new and old models of integrated health care delivery systems are sprouting rapidly.

It's little wonder, then, that the AMA in its current configuration has ceased being relevant to more and more physicians who aren't joining medicine's largest umbrella organization.

We can change that, but we must spring to action soon. What better time than now to support the recommendations of the Consortium of the Study of the Federation!?

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To Sue or Not to Sue

E. Wayne Martz MD

The other evening I was peripherally involved in a discussion which raises some troublesome issues regarding medical practice: care for the medically indigent poor and malpractice suits.

As you know the Medical Society initiated and is operating the Voluntary Initiative Program (VIP) to help the poor, the uninsured and those on Medicaid find access to medical care. We all recognize some professional, ethical responsibility to care for these people, but since one is guaranteed a financial loss in doing so, it seems appropriate that the loss should be distributed equitably over as many physicians as possible. It is truly a loss and not just foregone income, and time loss, as the office overhead continues unabated during the time the patients are being seen. We don't ask office staff, Delmarva Power and the landlord to provide their share free as well. I recall when the Urology Department at the Medical Center of Delaware gave up its residency program and closed the urology clinic, the physicians divided the clinic population equally among themselves and absorbed the patients into their private paying practices. It has worked well.

This is all well and good, but what happens if the patient sustains a bad result, whether through negligence or not? Suppose the patient fails to keep an appointment (which happens frequently in this group of patients) or fails to take a medication or have a procedure, or the doctor fails to report a laboratory result. Suppose the patient, with or without legal advice or urging, feels he might improve his financial position or at least be compensated for his suffering, and

files a malpractice suit. This adds insult to injury as far as the doctor is concerned, and partly because of this possibility, however remote, doctors are at times hesitant to see these patients. Granted that indigent patients almost never sue. Granted that even if one wanted to, 50 percent of the time he can't find an attorney to take the case, and if he does, 80 percent of such cases are thrown out of court. Nevertheless, it *could* happen.

Wait a minute. That is starting to sound like "lawyer talk." Of course, anything could happen. But will it? The probability is vanishing small. But even at that, doctor doesn't want to take the risk if they don't have to. The result is that VIP often has a difficult time finding a doctor to take patients who need care. The program is always in some danger of foundering, and something must be done. If they keep loading those patients on the doctors who reluctantly are willing to accept them, soon they become unwilling, and we no longer have an equitable distribution, and what should have been easy becomes difficult.

With this thinking in mind, in an effort to get more doctors to accept medically indigent patients, a bill was introduced into the legislature (HB 124) that would grant doctors immunity from suit (except for gross negligence) in cases in which they had rendered free service to patients referred to them by social agencies. It has been suggested that the patients be asked to waive their right to sue ahead of time by signing some sort of disclaimer when they go for medical care.

As a move to persuade more doctors to accept medically indigent patients and provide free service, this makes sense. It is not

ideal, but at least it is a move to assure care to those who need it and presently aren't getting it.

But there are other sides to the story. Some indigent patients are angered by this, saying, "We have always gotten second-class care, and here we go again. The doctors can be careless with us and we don't even have the basic right to sue." The attorneys also point out the difficulty separating simple negligence, for which these patients cannot sue, from gross negligence, for which they can. Moreover, the agreement not to sue is hardly worth the paper it's written on, as it was signed under duress. There is such a difference in the power position between the all-powerful doctor and the helpless, ailing patient that it just isn't fair.

Needless to say, HB 124 is generating some discussion in the legislature. There is some right on each side and some power on each side, so it could wind up an impasse like the budget battle. But we feel the doctor will always do his or her best for the patient. To do otherwise would be gross negligence.

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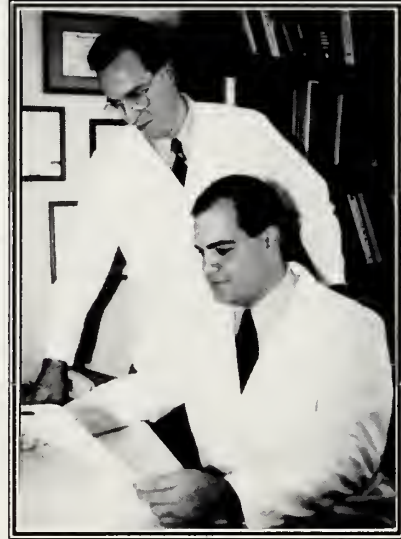


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An Implied Social Contract

James F. Lally MD

"The clear and present danger to medicine and public health is the substitution of profitability to investors rather than the health status of subscribers as the yardstick for measuring medical care."

Leon Eisenberg MD

Engraved on the Statue of Liberty is an inspiring statement, that reads in part: "Give me your tired, your poor, your huddled masses" In contrast, the motto of the for-profit HMOs could well read: "Give me the well, the employed, and don't let them ask too many questions."

Increasingly, the for-profit HMOs have skimmed off those at low risk for disease from the general population in an attempt to expand their already burgeoning lists of enrollees. With aggressive advertising, where hucksterism is thinly veiled as medical information and where Norman Rockwell-like pictures of a perfect family are depicted, they have skillfully acquired an increasing share of the medical market.

We — and it sometimes seems as if physicians have been bystanders to the process — have been witnesses to the incendiary rhetoric that followed the collision of the irresistible forces of commerce and medicine. Since they may daily confront and duel with the draconian regulations of managed care, many physicians find this revolution disguised as evolution profoundly affecting the way that they practice medicine. The role of the for-profit HMOs in the health care system has come under increasing scrutiny though. Per-

haps the pendulum will eventually swing the other way.

Economists, following Adam Smith's tenets, are inclined to speak of an "invisible hand" that drives and guides free markets. Metaphorically, the "invisible hands" of the for-profit HMOs dig deeper into the coffers of an increasingly limited medical care fiscal pie. Moreover, the venture capitalists of managed care ply their entrepreneurial skills on an uneven playing field. The nonprofit hospitals may charge paying patients more, but with cost shifting and accounting techniques, they provide free or reduced care to many. In 1993, according to the American Hospital Association, nonprofit hospitals provided \$9.2 billion worth of unpaid care while the for-profit hospitals paid \$886 million for those uninsured and unable to pay.

Perhaps it is idealistic and naive to view medicine as a community in which health care providers share equally in providing for the indigent and the uninsured. Nevertheless, those institutions charged with caring for the needy bear a burden that has been woefully ignored by the for-profit managed-care companies.

It is likely that investor-owned corporations will completely dominate the American health care system within the next few years. While most HMOs in the early 1980s were nonprofit over two-thirds in the early 1990s were for profit. Many project that this trend will continue unabated.

The for-profit HMOs may well answer the short-term medical needs of a community. Uwe Reinhardt, the health care economist at

Princeton University, likens them to the "bounty hunters" of the 19th century American west. He thinks that they fulfill a temporary need. Perhaps he's right that they are responding to a chaotic system in need of reform and a medical marketplace in transition. Reinhardt cautions though that, "a Wild West health system is one in which nice guys can easily finish last." The "nice guys" are physicians and hospitals that are saddled with much of the charitable care.

It is inconceivable that the long-term medical and societal needs of a community can be met by a market-driven medical care system that is focused on the proverbial bottom line and that constantly looks to a yearly rise in its stock value as the ultimate measure of its success. In 1994, Standard & Poor's index of 500 companies fell 1.5 percent; in that same year HMO stocks rose 32 percent. While several of the for-profit HMOs have been the darlings of Wall Street, they have conveniently eschewed their social obligations. Perhaps this is what Gandhi meant when he spoke of commerce without morality.

As the health policy expert Alain Enthoven has emphasized, "health maintenance organizations are financial intermediaries, they are not health care providers." They barter and bargain with the larger teaching and community hospitals for the lowest, discounted rate — and, yet, do they contribute to research? Do they provide care or fund immunization programs for deprived inner city children? Do they subsidize AIDS clinics or mental health clinics? Do they risk debt because they provided uncompensated care for some trauma victims? As a consequence of a profit-driven, corporate health system, are we as a society underinvesting in new and potentially beneficial technologies or treatment regimens? All of society benefits from research, technology and academic endeavors. With the for-profit HMOs, it is a *quid pro quo* in which one party has not met its contractual relationship.

The chief executive officers of the for-profit HMOs have not felt the economic squeeze and downturn that has affected the rest of the health care system. Indeed, these executives have reaped extraordinary profits (one critic used the word obscene) from their

health organizations. The chiefs of the seven largest for-profit HMOs averaged \$7 million in compensation in 1994. The chief executive of a large eastern US for-profit HMO has a net worth of \$750 million that he acquired from his HMO. This same HMO has profits of \$1 million dollars a day and has a cash reserve of \$1.2 billion dollars. A recent editorial in the *Philadelphia Inquirer* discussing health care issues and the compensation of the head of a local for-profit HMO stated, "It would appear that several million dollars that might be going to healing the sick or paying hospital charges are ending up in one man's pocket."

To some it is the American way and they are enjoying the fruits of an unfettered marketplace and the capitalist system. They are entrepreneurs — a sacred group that, next to lottery winners, generate thoughts of envy and admiration. Don't get me wrong or misread what I've said. I admire entrepreneurs such as Bill Gates who started with an unknown software program and is now worth billions. But computer software is a vastly different market from medical insurance. Not surprisingly, these capitalist endeavors make it easier for the for-profit HMOs to be dismissive of the consequences of their market decisions; it blinds them to their social obligations and shields them from social accountability.

In many of his writings, the emeritus editor of the *New England Journal of Medicine*, Arnold Relman, frequently emphasized that medicine is a social contract and not a business contract. He would agree that it is medicine's social contract that binds us as physicians to an indivisible system of morals and values, that places the common good well ahead of personal or corporate goals. It charges physicians to be the ultimate stewards and custodians of a covenant that traces its lineage to Hippocrates.

One may legitimately ask what the place of the for-profit HMOs is in the health care system. Will they continue to reap huge profits or will they respond to pressing health care needs? Or, more appropriately, will they sign on to a social contract that most of us as physicians signed onto long ago? The answer to that is the future of a health care system that hangs perilously in the balance.

OBITUARY

Alfred E. Bacon Jr., MD

William Shellenberger MD

Alfred E. Bacon Jr., MD, died January 4, 1996, of post-surgical complications in Christiana Hospital. He was 70 years old and lived in Greenville, Delaware.

Dr. Bacon grew up in Wilmington, graduating from Tower Hill School in 1943. He attended Yale University and was a 1949 graduate of the Yale School of Medicine. He served in the Navy during World War II, and was a Navy physician during the Korean War. He did his clinical training at the Delaware Hospital and the University of Pennsylvania.

In 1955, he opened a private practice of internal medicine on N. Van Buren Street, later focusing on cardiology. He and Dr. Bernadine Paulshock were the first home care physicians sponsored by the Delaware Hospital in the 1960s. He was director of medicine at the Wilmington General Hospital and, after the merger into the Medical Center of Delaware, became head of the MCD cardiology section in 1976.

Dr. Robert E. Flinn, present chairman of medicine at the MCD, stated that, "Al played a vital role in the modernization of cardiology section at the Medical Center and was instrumental in getting the heart surgery program started." He had joined the cardiology section at St. Francis Hospital in 1956, becoming director of the department of medicine there before heading the cardiology section in 1980. He was much involved in developing their intensive care unit and the cardiac catheterization lab.

Dr. Bacon was also director of house staff education at the Delaware Division. His son, Dr. Alfred E. Bacon III, an infectious disease specialist in Wilmington, noted that his father was "a strong nurse and peer educator."

Dr. Bacon was much involved in other medical affairs. He was a member of the state Board of Medical Examiners from 1965 to 1974,

and was vice-president for two years. He was a fellow of the American College of Cardiology and former governor for the state of Delaware; former president and chairman of the board of the Delaware Chapter of the American



Alfred E. Bacon Jr., MD

Heart Association; former president of the Delaware Academy of Medicine; and he served on the board of directors of the Medical Center of Delaware from 1980 to 1990.

He was a member of the Yacht Club of Stone Harbor (New Jersey), the Greenville Country Club, and the New Castle County Medical Society and the Medical Society of Delaware.

His principal avocation, before and after he retired, was sailing, which he loved. In his latter years, when cruising the Chesapeake became too arduous, he spent much of his time fishing and fixing his boat at Stone Harbor, his summer home.

Al was extremely well-liked and respected by his peers, nurses, hospital staffs, friends and patients as a fine physician and a kind, caring person. He could cut to the root of problems rapidly and decisively, but always tempered this with his quick, infectious sense of humor.

He is survived by his wife, Joan Truss Bacon; his son; daughters, Abigail Robinson Bacon of Charleston, South Carolina, and Susan Bacon Dynerman of Washington; a brother, Robert, of Houston, Texas; and four grandchildren.

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Cancer Screening and the USPSTF

James M. Gill MD MPH

I was happy to see that my article on evidence-based preventive care¹ inspired lively responses. I think this is an important topic which deserves thoughtful discussion and debate.

As I stated in my article, it is important to develop office reminder systems to help us to perform appropriate preventive services to our patients. I agree with the recommendations of Dr. Chodos¹ and other authors^{2,3} that physicians should implement such reminder systems in their practices. However, I feel that such systems should remind us to do things which really benefit patients. What is beneficial to patients is often a topic of debate, as pointed out by Dr. Frelick and Dr. Chodos.^{1,4} However, I had hoped that my article would help physicians to change the way they frame the debate. The debate should be framed by the simple question, "Is there any evidence that what we do is beneficial, and if not, why not?" The new guidelines of the U.S. Preventive Services Task Force (USPSTF)⁵ help physicians to sort out these issues, and are a good example of "evidence-based medicine."

Unfortunately, the recommendations of the USPSTF are often misinterpreted. It is often believed that the USPSTF recommends screening only if it has been unequivocally proven to be beneficial in randomized clinical trials (RCTs). If this were the case, then their recommendations would certainly be very conservative and would be applicable to few clinical scenarios. However, this is not the

case. The USPSTF looks at all the available evidence and asks, "Does the weight of the evidence support the notion that this intervention is beneficial?"

In some cases, there are well-designed RCTs which give us a clear answer (e.g., breast cancer screening is clearly beneficial in women ages 50 to 69, and lung cancer screening is clearly not beneficial). However, when good RCTs are not available, the USPSTF uses other evidence to make its decision. For example, PAP smears are strongly recommended even though RCTs have never been done. Mathematical models are also used as evidence (e.g., the results of decision-analysis models supported the recommendation against screening for prostate and ovarian cancer).

There are many studies which do not measure outcomes directly, such as those which show an association between screening and early detection. While these studies are used by the USPSTF as supportive evidence, they cannot be used alone as direct evidence that the screening is effective. Early detection does not necessarily translate into improved outcomes (as is the case with prostate cancer), and even if outcomes can be improved for some patients, this may be outweighed by the harm done to other patients through unnecessary tests and surgery (as is the case with breast cancer screening for young women).

Another misinterpretation about the USPSTF is that cost is their primary reason for recommending against screening. This is

incorrect. The USPSTF first determines whether screening improves outcomes. If it does not, then cost is irrelevant, since there is no benefit to measure the cost against. If it does, then the USPSTF recommends it regardless of the cost (e.g., they recommend colorectal cancer screening, despite the enormous cost associated with following their recommendations). The only time they consider cost in their decision is when the benefits of screening are equivocal.

Finally, it is often believed that the USPSTF presents a "cookbook" approach to medicine, where physician judgement and individual patient preferences are ignored. This is not true. Their recommendations are graded according to the strength of the evidence. When there is reasonably good evidence that screening is effective (as with mammograms in women ages 50 to 69 or PAPs in women up to age 65), they recommend screening. When there is reasonably good evidence that screening is not effective (as with lung, prostate, and ovarian cancer), they recommend against screening. However, in many cases there is no good evidence for or against screening (as with skin, testicular, or oral cancer, as well as breast cancer in younger women); in these cases, they do not recommend for or against, but leave the decision to clinical discretion. While they do not recommend for or against these "unproven" screening tests, they encourage physicians to consider their risks and benefits; many physicians may not want to expose their patients to the possible risks of these unproven tests.

Even when they clearly recommend for or against a test, the USPSTF recognizes that appropriate care may differ for individual patients, and that clinical discretion is always needed. The USPSTF also encourages physicians to discuss the risks and benefits of all screening tests with their patients. For example, some women in their 40s might want to undergo breast cancer screening; however, these women should know that for them, screening has never been shown to be beneficial, and that the chance of harm is as likely as the chance of benefit.

Physicians have always used guidelines to help them make medical decisions. In the past, these guidelines have usually come in the form of dictums from medical school professors, chapters in textbooks, or collections of anecdotal experiences. Until recently, there were few guidelines for primary or preventive care that were based on scientific evidence that was collected and weighed through a rigorous methodology. Recently, this has changed.

The Canadian Task Force, and now the USPSTF have provided physicians with guidelines for preventive care that are based on strong scientific evidence and that are reasonable and flexible. In cases where scientific evidence is lacking, physicians must still rely solely on their clinical judgement. However, when evidence becomes available that disproves the benefit of medical practices, physicians must be able to respond to this new evidence by discarding these disproven practices. The USPSTF guidelines provide physicians with a tool to know when this change in practice is appropriate and when it is not.

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MSD MONTHLY ACTIVITIES

Working for You: April 1996

Leadership Activities

- Mr. Meister attended a conference on federalism and welfare reform sponsored by the Delaware Public Policy Institute at the University of Delaware.
- Virginia U. Collier MD and Mr. Meister attended a meeting with representatives of the Delaware Academy of Medicine and the Thomas Jefferson University, to discuss the formation of a state-wide video-conference network.
- Drs. Tavani, Permut, and Pereira-Ogan, Phil Corrozi, Mr. Meister and Representative Maroney met with representatives of Delaware's major insurers and the Delaware Insurance Commissioner to discuss regulating managed care.
- Drs. DeLaurentis, Kramer and Schindler traveled to Lawrenceville, NJ to meet with representatives of the Medical Society of New Jersey's physicians' health program.
- Dr's Tavani and Permut, Phil Corrozi, Mrs. Dieffenbach and Mr. Meister met with representatives of the Delaware Trial Lawyers Association to discuss common concerns regarding managed care.

Physicians' Advocate Program Activities

- Presented the workshop "How to Write a Personnel Policy Manual" in both Georgetown and Newark.
- Finalized plans for the Second Annual EDI Expo on May 15.
- In conjunction with DMGMA, offered the first of two all-day coding workshops in April.
- Attended a meeting with representatives from DuPont EAP Program, three New

Castle County physicians, regarding deselection from the panel.

- Provided consulting to two area offices, focusing on Accounts Receivables and Practice Evaluation. The program also provided an office inservice on Front Desk Procedures and offered ongoing support for two physicians starting their own practice.
- Assisted in the coordination of the first meeting of the Xact Transition Consulting Team.
- The 1996 Managed Care Contracting Service began its second year of service with a mass mailing to all active MSD members. Numerous medical practices have enrolled thus far for the 1996 program and requests for the 1995 series continue to be received.

Credentials Verification Organization (CVO)

- Began meeting with medical staff coordinators from local hospitals.
- Met with State Board of Medical Practice.
- Met with attorney for development of CVO contract.
- Developed brochure for customers.
- Developed policies and procedures for the program.

Continuing Medical Education Activities

- Sponsored 22 educational activities for Category 1 credit.

Other Activities

- The following physicians served as "Doctor of the Day" at Legislative Hall in the month of April: Rhoslyn J. Bishoff MD, E. Wayne Martz MD, Jorge A. Pereira-Ogan MD, Richard H. Sherman MD.

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Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting.

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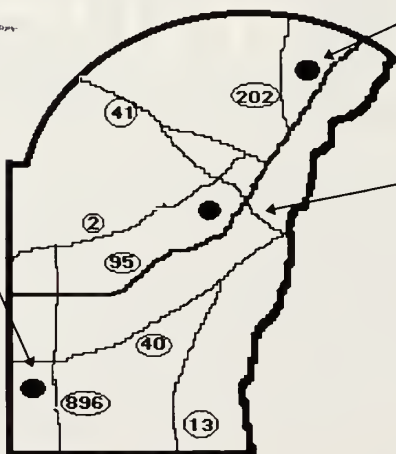
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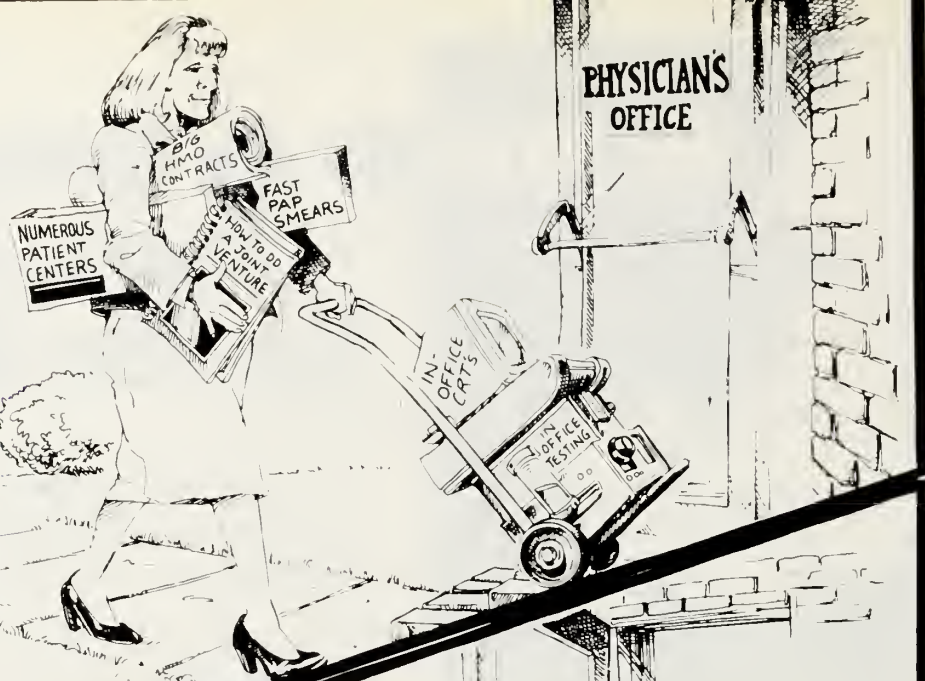
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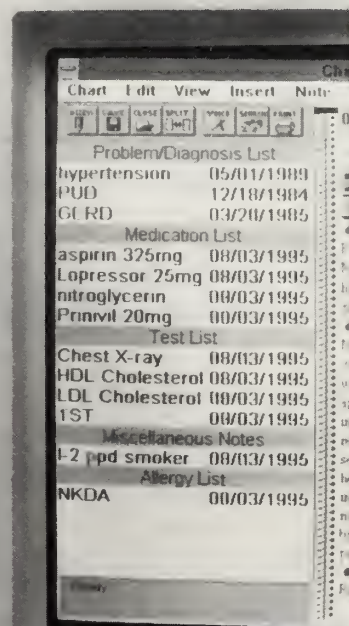
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Caretaker Or Criminal: Or, How To Get In Trouble Without Really Trying

The recent passage by both Houses of Congress of incremental health insurance reform legislation, which now goes before a conference committee, provides a timely and important topic for this month's President's Page. Although both bills contain some valuable provisions, such as portability, guaranteed renewability, preexisting condition modifications, individual market reform, and better ability to form purchasing groups, there are issues of serious concern to physicians. This legislation (H.R.3103 in the House and S.1028, the Kassebaum-Kennedy Bill, in the Senate) contains fraud and abuse provisions, language which dramatically increases enforcement authority. If enacted, the House Bill would subject physicians to criminal prosecution and fines for conduct not necessarily recognized as illegal since it requires an offense to be "knowing" but not "knowing and willful." (The Senate Bill contains both criteria, which are essential to ensure that inadvertent or accidental conduct is not considered criminal).

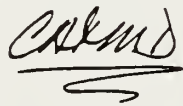
Most allegations of health care fraud by physicians involve some aspect of billing (source: Federation Government Affairs Staff, American Medical Association), and there is much ambiguity and complexity contained in the CPT coding system, as well as subjectivity involved in the level of complexity of treatment. The AMA devotes tremendous resources to interpretation and explanation of these codes. Fraud enforcement agencies use the AMA in consultation to help them under-

stand and interpret these codes. Therefore, it is critical to distinguish mistaken coding from intentional misconduct. Judgments regarding medical necessity and referral would be similarly vulnerable. In addition, both versions would mandate the use of new commercial software technologies for the Medicare program, but the content of these commercial products would not be disclosed. Such "black box" review screens cannot be tolerated without ever being developed and reviewed with physician input.

Physicians should have the ability to obtain written, binding opinions from enforcement agencies as to whether or not an anticipated activity or conduct is allowable. The Senate Bill does not consider these interpretive rulings binding. Both bills provide for creation of a Health Care Fraud and Abuse Account, funded by criminal fines, civil penalties, and forfeited property. The AMA has specifically opposed such means of funding of a governmental program, which could clearly represent incentives impairing objective enforcement implementation. Finally, the AMA has requested that any penalties be commensurate with the offense committed, and that final adverse actions submitted to the Data Bank only target serious infractions.

What can physicians do to ensure that careful, fair, thoughtful legislation is the end result of all this? The AMA has been lobbying to change the offensive sections of the Bill throughout this whole process. However, in-

dividual physicians can help. Contact our Senators (Senator Roth was identified as a potential Conferee) and Representative and voice your views. The Medical Society and the Association of Delaware Hospitals have joined together to express these concerns. Our executive director, Mark Meister, and your president, engaged in a conference call just this morning with Senator Roth's Washington staff. As with our other endeavors, however, the impact must emanate from all of us together as a single, unified, organized, powerful whole. Make your call, voice your view, and make a difference today.



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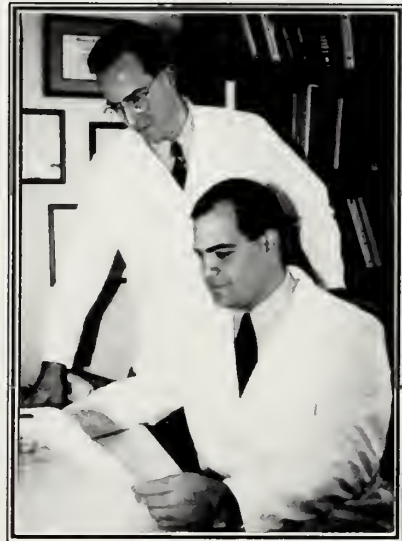


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Clinical Relevance of Presenting Symptoms in the Preoperative Evaluation of Pelvic Masses

James A. Levey MD
James E. Larson MD

Abstract

Background: There are few studies which have analyzed patients' presenting symptoms to evaluate whether a particular symptom is clinically significant. This study is aimed at determining whether any particular presenting symptom is important in the preoperative evaluation of a pelvic mass.

Materials and Methods: 130 charts of patients presenting with a pelvic mass were reviewed. A standard data collection technique was used to determine rate of occurrence as well as clinical statistical relevance of specific symptoms.

Results: 25 malignancies, 16 of gynecologic origin, were found. Of the variables studied, women older than 50 showed a 14 fold increase in RR (OR 23.3, 95 percent CI 5-104.8) and those with abdominal distention showed an OR 7.9 (95 percent CI 2-21.5).

Conclusions: Abdominal distention showed statistical significance and may be useful in the preoperative assessment of a pelvic mass.

Introduction

A common problem encountered by the gynecologist is the evaluation of a pelvic mass. Although the majority of these masses are benign, most patients undergo exploratory laparotomy. There is an increasing trend toward using laparoscopy for both diagnosis and treatment. A reliable test or indicator for the risk of malignancy would greatly aid the clinician in choosing the proper surgical approach, arranging oncologic support, and reduce the number of exploratory procedures.

None of the screening tools presently used by the gynecologist including ultrasound, computerized tomography (CAT), carcinogenic antigen 125 (CA 125), have been reliable enough in the preoperative evaluation of the pelvic mass to reliably make those choices.

During the preoperative work up of a patient with a pelvic mass a general history and physical examination are standard. Many argue that clinical impression has little or no predictive value in differentiating benign and malignant disease.¹ However, there are few studies which have analyzed patients' presenting symptoms to evaluate whether a particular symptom is clinically significant. This study is an attempt to determine the clinical relevance of specific patient symptoms.

The majority of studies on pelvic masses are conducted at large academic referral centers. Clinical protocols derived from those studies assume a similar rate of disease in the general population. Although this study was conducted at a tertiary care center, the Medical Center of Delaware is a community hospital. The study also attempted to compare the published incidence with that of a community hospital.

Materials and Methods

A case-controlled retrospective review of all female patients presenting to the Medical Center of Delaware with the admitting diagnosis of adnexal (ICD 9 code 625.8) and or pelvic (ICD 9 code 789.3) mass between July 1, 1990 to June 30, 1991 were analyzed. One hundred thirty-three women presented for admission during this period. One hundred thirty charts were reviewed. Three charts were not available for review. All of the pa-

tients had a histologically undiagnosed mass. Care was provided at Christiana Hospital, The Medical Center of Delaware, Newark, Delaware.

Data was abstracted from the medical record of the index admission. A standardized collection and recording technique was employed. Clinical data collected included the patient's medical, surgical, family and social history. Laboratory, including pathologic and radiological data was also collected. Special attention was focused on the patient's presenting symptoms.

The information was compiled using Microsoft Excel and Access. For each symptom sensitivity, specificity, positive predictive values (PPV), negative predictive values (NPV) and odds ratios (OR) with confidence intervals (CI) were calculated. Sensitivities, specificities, and predictive values were calculated using only those symptoms which were consistently recorded. Statistical analysis was performed using Systat package. The data was collected by one author who was consistent in terminology accepted as an affirmative reply. If a particular symptom was not mentioned, it was assumed to be a negative reply.

Results

Of the 130 charts reviewed, there were 25 malignancies, a malignancy rate of 19 percent. Six (24 percent) of the 25 malignancies were non gynecologic, including two breast cancers, one lymphosarcoma, one lymphoma, one neuroectodermal tumor, and one ureteral cancer. Nineteen (76 percent) of the 25 malignancies were gynecologic and included 16 epithelial tumors, two mixed mullerian tumors, and one fallopian tube cancer. Five of the epithelial cancers were tumors of low malignant potential. The gynecologic cancer rate for all patients presenting with a pelvic mass was 14 percent. Six (0.5 percent) of the patients underwent diagnostic laparoscopy. All of these patients except one had no other form of surgical treatment. All six of these cases were benign. The remainder of the patients had exploratory laparoscopy as the definitive diagnostic procedure. Out of the 19 gynecologic malignancies 14 (73.6 percent) were sur-

gically staged by a board certified gynecologic oncologist.

The average age of those individuals without a malignancy was 45.6 years compared to 65.8 years for those with a malignancy. A patient older than 40 who presents with a pelvic mass showed a nine fold increase in relative risk (OR 12.3, 95 percent CI 1-95.1) of having a malignancy. Women older than 50 showed a 14 fold increase in relative risk (OR 23.3, 95 percent CI 5-104.8). The average gravity was 2.4 for those with and without malignancy. Those patients who were parous showed a relative risk of 0.75 (OR 0.71, 95 percent CI 0-3.5).

Patients who were asymptomatic made up 21 (20 percent) of those without and 3 (12 percent) of those with malignancy. Patients with abdominal discomfort made up 55 (52 percent) of those without and 13 (52 percent) of those with malignancy. Using any other GI symptom as the clinical indicator reveals that 18(17 percent) of those without and 8(32 percent) of those with malignancy had this complaint. When urinary symptoms were used as the clinical indicator one finds that 8(<1 percent) of those without and 1 (<1percent) of those with malignancy had this as a presenting complaint. Weight loss reveals 6(<1 percent) without and 4 (25 percent) of those with malignancy had this complaint. Patients with abdominal distention made up 11 (10 percent) of those without and 12 (48 percent) of those with malignancy and was the only symptom to reach statistical significance.

The other two clinical symptoms collected from the data, dysmenorrhea and evidence of abnormal bleeding did not have enough responses found during the review to be included. Table I presents each symptom's statistical significance by sensitivity, specificity, positive and negative predictive values, and odds ratio with 95 percent confidence intervals. Age greater than 50 as well as abdominal distention as variables generated sample sizes large enough to obtain 80 percent power. The remainder of the variables would require larger sample sizes to have generated such a power.

	sensitivity	specificity	PPV	NPV	OR (95% CI)
Asymptomatic	0.12	0.80	0.13	0.79	0.54 (0-2.0)
Abdominal Distention	0.48	0.89	0.52	0.88	7.9 (2-21.5)
Abdominal Discomfort	0.52	0.47	0.19	0.81	0.98 (0-2.4)
Other GI Symptoms	0.32	0.83	0.31	0.84	2.2 (0-6.1)
Urinary Symptoms	0.04	0.92	0.11	0.80	0.51 (0-4.2)
Weight Loss	0.16	0.94	0.40	0.82	3.14 (0-12.1)

Table 1. Statistical summary of data with sensitivity, specificity, PPV (positive predictive value), NPV (negative predictive value), OR (odds ratio with 95 percent confidence intervals).

Discussion

A 19 percent malignancy rate with 76 percent of these being gynecologic and 24 percent being of non gynecologic origin is within expected rates.^{2,3} If this holds true at other community centers, protocols to modify the planned procedure and or oncologic support as described by academic centers may be justifiable in community facilities. There was no statistical difference between the two groups in relation to their gravity. There was a trend toward showing the protective effects of childbearing as demonstrated by a relative risk of 0.75, although the confidence interval did include one. This is most likely secondary to a small sample size.

The average age of malignancy was 65.8 years as compared to 45.6 years for those with benign disease. Statistical analysis revealed that patients above the age of 50 presenting with a pelvic mass were at a significantly increased risk of having a malignancy. Age appears to be a consistent indicator of increased risk of malignancy.

The only symptom analyzed as a clinical indicator of malignancy which showed any statistical significance was abdominal distention. Since sample size was small, even with 80 percent power, it would be improper to assume that this clinical symptom could be used solely as a reliable indicator of malignant disease. The data implies that it could be used as an adjunctive tool with other screening modalities. With larger sample sizes some of the other indicators could become significant. Perhaps there is another presenting clinical symptom not usually

asked of the patient and not investigated here which may also have relevance. The data from this study argues that clinical symptoms most often queried cannot alone be considered accurate enough to help stratify the risk of malignancy.

Barber and Graber's article describing the postmenopausal palpable ovary syndrome was significant for making the gynecologist aware of the increased risk of ovarian cancer in a particular subset of patients.⁴ Gynecologists have since attempted to find effective screening methods for ovarian cancer beyond the physical exam. Although many screening modalities have been employed and advocated including ultrasound, CAT scan, CA 125 to name a few, the only consistent finding it that the risk increases with the age of the patient and the size of the neoplasm. Reeves et al even found that there was no significant difference in measurement accuracy between ultrasound, the most commonly used screening modality for lesion size, and the physical examination.⁵

Some investigators have attempted to combine different screening modalities in an attempt to better define risk stratification. Parker et al suggested that with certain criteria found on physical examination, blood tests, and roentgenographic examinations one could hypothesize which individuals presenting with a pelvic mass had cancer and which could successfully undergo laparoscopy for diagnosis and treatment.⁶ However, few women presenting with a pelvic mass fit the criteria. Yet in today's medical climate of cost containment as well as patient desires there

is an ever growing role for laparoscopy. Given that four out of five patients presenting with a pelvic mass will not have a malignancy, it becomes evident that valuable resources are being consumed to detect benign disease.

In this study only 0.5 percent of the patients underwent some form of diagnostic treatment other than abdominal exploration. A test which could definitively rule in benign disease would be just as useful to the clinician. This indicator does not currently exist and the data suggests that clinical presentation has a limited role in discriminating between benign and malignant disease.

Conclusion

Presently there are numerous screening tests and risk stratification schemes being employed on patients presenting with a pelvic mass in an attempt to increase the gynecologists ability to differentiate benign and malignant disease. The aim of this study was to determine whether any clinical symptoms as provided by the patient could aid the clinician. The data supports the use of the clinical symptom of abdominal distention in the preoperative assessment. It seems prudent that in post menopausal women with large masses and abdominal distention to proceed with exploratory laparotomy.

Acknowledgement

The authors would like to thank Robert Gorman PhD for his assistance with the statistics.

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Physician Performance of Preventive Care for Women

James M. Gill MD, MPH

Abstract

Background

The purpose of this study was to examine whether academic primary care physicians recommended appropriate preventive care to their female patients, whether recommendations differed for different types of physicians, and how often these recommendations led to completion of the preventive service.

Methods

A retrospective chart review was conducted in the family medicine and internal medicine outpatient practices at the Medical Center of Delaware (MCD). A total of 324 women ages 40 and over were selected from the patient panels of nine faculty and 14 residents. Physician recommendation of PAP smears, mammograms, breast exams, and influenza immunizations were measured against the guidelines of the U.S. Preventive Service Task Force. Specifically examined was whether rates of recommendation differed by specialty, gender and faculty/resident status of the physician. Also measured was completion of each preventive service and whether rates of completion differed from rates of physician recommendation.

Results

Physicians recommended appropriate PAPs in 72 percent of patients, mammograms in 83 percent of patients, breast exams in 46 percent of patients and influenza immunizations in 30 percent of patients. Family physicians were more likely to recommend PAP smears (odds ratio 5.53, 95 percent confidence interval 2.26-12.98), but not more likely to recom-

mend other services; female physicians were more likely to recommend breast exams (odds ratio 3.48, 95 percent confidence interval 2.05-5.89), but not other services. There were no significant differences between faculty and residents. Preventive services were completed in 48 percent of patients for PAPs, 68 percent for mammograms, 42 percent for breast exams, and 27 percent for flu shots.

Conclusions

In academic primary care practices at MCD, physicians perform well in recommending PAPs and mammograms, but not in recommending breast exams or influenza immunizations. There were few differences in performance among different types of physicians. Because many women did not follow through with their physicians' recommendations for preventive care, physician performance is more accurately measured according to their recommendations rather than completion of services. Efforts to improve preventive care in women should differ depending on whether the problem lies in physician performance or patient behavior.

Introduction

Despite increasing attention to women's health,¹ many women do not receive adequate preventive health care.²⁻⁴ With the advent of managed care, physicians are increasingly being held responsible for providing appropriate preventive services to their patients.⁵ Third party payers often audit the medical records of participating physicians to determine if these physicians are providing appropriate preventive services to their patients.

Physicians who are considered "poor performers" may be subject to reduction of reimbursement or denial of participation.

In addition to assessing the performance of individual physicians, chart audits are sometimes conducted to assess the performance of groups of physicians and to determine if certain types of physicians perform preventive care better than others. For example, some studies have suggested that preventive care for women may vary depending on the specialty⁶⁻⁹ level of experience¹⁰ or gender^{7,11} of the primary physician. Such findings can lead to women being discouraged from utilizing the types of physicians with lower rates of preventive care.

It is questionable whether these studies and chart audits accurately represent physician performance. The audits conducted by insurance companies frequently fail to employ rigorous scientific methods, and usually do not take into consideration differences in patient populations, which may influence receipt of preventive care. Even well-designed scientific studies are often limited in their ability to measure physician performance. One reason is that most studies examine performance by whether preventive services are completed^{2,3,7,12} rather than whether they are recommended by the physician. Since many factors influencing patient utilization may not be under the physician's control,^{2,3,12-16} physician performance might be more accurately assessed by whether they offer or recommend preventive care to their patients. Also, the standards against which performance is measured vary and are often of questionable validity. Physician performance is often measured for preventive services which have not been shown to be beneficial (e.g., rectal exams)^{6,8,13} or for which there is debate regarding their benefit (e.g., mammograms in women under age 50)^{6-8,13}. When assessing performance, physicians should be held accountable only for services which are known to be beneficial based on the best scientific evidence.

The purpose of this study was to examine performance of preventive care for women among family physicians and general internists in academic practices at the Medical

Center of Delaware. Performance was defined according to whether the physicians recommended appropriate preventive services to their patients. Appropriate services were defined according to evidence-based guidelines. It was examined whether performance differed by the specialty, level of experience (resident vs. faculty) and gender of the primary physician. Finally, the extent to which physician recommendations resulted in the woman having the preventive service completed was also examined.

Methods

Study Setting

The study was conducted at three outpatient facilities of the Medical Center of Delaware (MCD): the internal medicine clinic of the outpatient department (OPD), the internal medicine faculty practice and the Family Medicine Center (FMC). These sites were chosen because they are where residents and faculty in internal medicine (IM) and family practice (FP) see patients for comprehensive primary care. IM residents see patients in the OPD, which is located in the hospital outpatient department of the Wilmington Hospital. IM faculty see patients in the internal medicine faculty practice, located in an office suite on the fifth floor of the Wilmington Hospital. FP faculty and residents see patients at the Family Medicine Center (FMC). The FMC was located in the Wilmington Hospital during the first half of the period of analysis, then moved to a suburban office in North Wilmington.

Patient Selection

Patients were eligible for the study if they were women age ≥ 40 , had health insurance, and were regular patients of a faculty or third-year resident at one of the study sites. A regular patient was defined as one who had visited the office at least twice in the previous two years. Patients of first and second year residents were not included because these physicians often have too few regular patients to provide stable estimates. Uninsured women were excluded because only one site (the OPD) had a significant number. Physicians included three IM faculty (1 female), 6

IM residents (1 female), 6 FP faculty (2 female) and 10 FP residents (2 female). Up to 22 patients were randomly selected for each physician.

Data Collection

Data were collected by a medical student by a retrospective chart review which covered a three-year period (7/1/90 to 7/1/93). Four preventive services were examined:

Papanicolaou (PAP) smears, mammograms, breast exams, and influenza immunizations. Appropriate preventive services were defined as at least one PAP smear within the previous three years for women ages 40-65, at least one mammogram within the previous two years for women ages 50-75, at least one breast exam in the previous one year for women ages 40 and older, and at least one influenza immunization within the previous year for women ages 65 and older. These criteria were derived from the guidelines of the U.S. Preventive Services Task Force.¹⁷ These guidelines were chosen for three reasons. First, they are "evidence-based" guidelines, i.e., they are based on rigorous review of the scientific evidence. Second, they represent a minimum standard for which there is little disagreement.¹⁸⁻²⁰ Finally, the guidelines are widely known in the U.S.^{21, 22}

Each preventive intervention was measured in two ways: whether it was recommended to the patient by the physician and whether it was completed. A procedure was considered recommended if a medical record notation indicated that the physician had performed the procedure, ordered that the procedure be done, or recommended to the patient that it be done. A procedure was considered completed only if the medical record contained a notation indicating that the test had actually been completed. Data were also collected on patient demographics (age, insurance and distance lived from the office), risk factors for cervical cancer (multiple sexual partners or a previously abnormal PAP smear), risk factors for breast cancer (personal history of breast cancer or a history of breast cancer in a first-degree relative), and number of office visits made over the previous three years.

Statistical Analysis

In the primary analysis, the proportion of women who had each preventive service recommended was calculated. These proportions were compared for subgroups of women who used different types of physicians (IM faculty, IM resident, FP faculty, FP resident) as their primary physician. The proportions were also compared for patients of male versus female physicians. The differences across physician type and gender were analyzed using a Chi-square test. Multivariate logistic regression was conducted to determine whether these differences persisted after controlling for patient demographics, cancer risk factors, and number of office visits.

In a secondary analysis, the proportion of women who had each preventive service completed was compared to the proportion who had the services recommended by her physician. For all analyses, the patient was the unit of analysis and $p < 0.05$ was the cutoff for statistical significance.

Results

A total of 324 patients were included in the study. The distribution of patients by primary care physician characteristics, patient demographics and risk factors is shown in the Table. Patients had a median of nine office visits over the three year period.

Overall, physicians recommended appropriate PAPs in 72 percent of patients, mammograms in 83 percent of patients, breast exams in 46 percent of patients and influenza immunizations in 30 percent of patients. Differences across physician types are illustrated in Figure 1. In bivariate analysis, FP faculty were the most likely to recommend PAP smears, followed by FP residents, IM residents and IM faculty. The higher rates for FPs persisted after controlling for other variables in multivariate analysis (odds ratio 5.53, 95 percent confidence interval 2.26-12.98). There were no other significant differences by physician type.

The differences by physician gender are shown in Figure 2. In bivariate analysis, female physicians were more likely to recommend PAP smears and breast exams. After controlling for other variables, this difference

Patient Distribution by Independent Variables (N=324)

Physician Type		# of Pts (%)	
Family Practice	- Faculty	76	(24%)
	- Resident	88	(27%)
Internal Medicine	- Faculty	64	(20%)
	- Resident	96	(30%)
Physician Gender		# of Pts (%)	
Males		224	(69%)
Females		100	(31%)
Age		# of Pts (%)	
40-49 years		66	(20%)
50-59 years		58	(18%)
60-69 years		95	(25%)
70-79 years		72	(22%)
80+ years		33	(10%)
Insurance		# of Pts (%)	
Medicaid		123	(38%)
Medicare Only		50	(15%)
Medicare + Commercial		63	(20%)
Managed Care		23	(7%)
Commercial		65	(20%)
Distance lived from office		# of Pts (%)	
0-2	miles	77	(24%)
2-5	miles	103	(32%)
5-10	miles	80	(24%)
>10	miles	64	(20%)
High Risk For Cervical Cancer		# of Pts (%)	
Yes		13	(4%)
No		160	(49%)
Not applicable (age >65)		151	(47%)
High Risk For Breast Cancer		# of Pts (%)	
Yes		70	(22%)
No		254	(78%)

Table 1.

persisted for breast exams (odds ratio 3.48, 95 percent confidence interval 2.05-5.89), but not for PAP smears.

Appropriate PAPs were completed in 48 percent of women, mammograms in 68 percent, breast exams in 42 percent and flu shots in 27 percent. Figure 3 shows the difference between physician recommendation and completion of preventive services. A substantial proportion of women who had PAP smears and mammograms recommended never had the procedure completed. This was not true for breast exams or influenza immunizations.

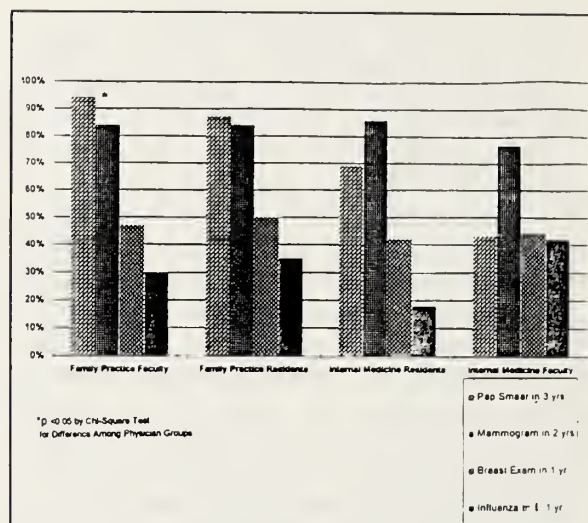


Figure 1. Physician Recommendation of Preventive Services According to Physician Type.

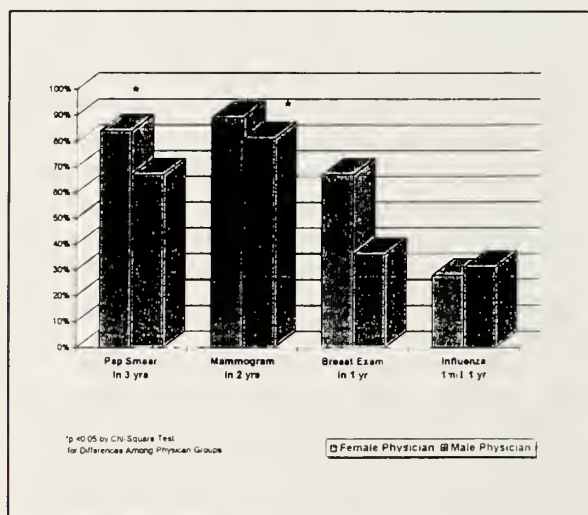


Figure 2. Physician Recommendation of Preventive Services According to Physician Gender.

Discussion

This study reveals a mixed report regarding physician performance of preventive care in women. Physicians recommended appropriate PAPs and mammograms in a high percentage of their patients. However, physicians recommended appropriate breast exams and influenza immunizations in fewer than half of their patients. There are a number of reasons why physicians may fail to recommend appropriate preventive services to their patients. One reason could be that physicians are re-

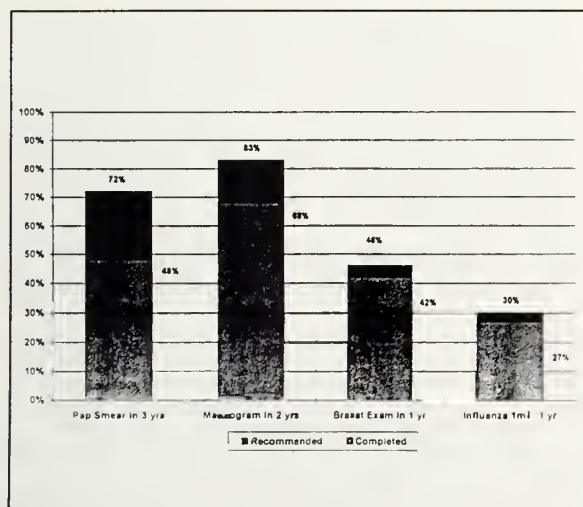


Figure 3. Physician Recommendation and Completion of Preventive Services in Women.

luctant to include preventive care during office visits that are not intended for prevention.²³ This is despite guidelines which recommend that preventive care be addressed at every patient encounter.^{17,20}

Another reason could be physician forgetfulness or lack of time.²⁴ It could be that physicians did not recommend influenza immunizations if they did not see the patients during the season when these immunizations are given. It could also be that some primary care physicians did not address gynecologic screening for patients who also receive care from a gynecologist. However, one of the basic tenets of primary care is "coordination of care," regardless of when or by whom that care is performed.²⁵ As managed care becomes more prevalent, primary care physicians are increasingly being held accountable for providing comprehensive and coordinated care.

The differences in performance among physician groups were fewer than expected. Family physicians were more likely than internists to recommend PAP smears, but were not more likely to recommend other preventive services. Female physicians were more likely to recommend breast exams, but not other services. There were no differences between faculty and residents for any preventive services. These findings may seem to conflict previous studies which found physi-

cian specialty and gender to be strongly associated with preventive care.^{7,8} However, these studies measured completion of tests rather than physician recommendations, and did not use evidence-based guidelines as the gold-standard. Only one previous study measured physician recommendations for different specialties, and found no differences.²⁶

The difference between a physician recommending a service and the service being completed is well illustrated in this study. A substantial number of women who were offered PAPs and mammograms by their physician never had these services completed.

If these rates of completion had been used as an indicator of physician performance, as often is the case with managed care reviews, physician performance would have been rated as worse than it actually was. There are many reasons why women may not follow through with their physicians' recommendations. First, women may be reluctant to make a special visit for preventive care. This hypothesis is supported by the finding that lack of follow-through with recommendations was most pronounced for PAP smears, a procedure that is likely to require a return visit. There could also be financial barriers to completing preventive services, especially when insurance does not cover the service or co-payments are required.²⁷ Finally, women who feel that preventive services offer little benefit to them may be less likely to follow through with their physician's recommendation.^{15,16} Because physicians have little control over many factors influencing a woman's decision to pursue preventive care, measuring physician performance by completion of services may be misleading.

Understanding the difference between recommendation and completion of preventive care is important not only in measuring physician performance, but also in attempting to improve rates of preventive care in women. For example, where rates of physician recommendation are low (as was the case with breast exams and influenza immunizations), policies that target physician behavior may help to improve rates of preventive care. Physician education may improve performance for those physicians who

are less knowledgeable about preventive care guidelines.²² Physician reminder systems, such as preventive care flow sheets or computerized reminders may also increase preventive care.²⁸⁻³⁰ Finally, increasing the involvement of nurses and other staff may help.³¹

However, in cases where physicians appropriately recommend services but patients do not have them completed, these physician-targeted interventions are unlikely to be successful. In such cases, efforts must target the patients' reasons for not following through with the services. Such efforts might include patient awareness and education, patient reminders,²⁹ improving access to preventive services, or improved insurance coverage of preventive services.³²

There are a number of limitations that must be considered when interpreting the results of this study. First, chart reviews may not accurately depict physician behavior. For example, some physicians may have recommended preventive services but not recorded this in the chart. However, medical records are the most accurate data source we have to represent what takes place in a physician's office, and are often used as a gold-standard against which to measure the accuracy of other data sources.³³⁻³⁶ The accuracy of chart review might be a larger issue when measuring completion of tests. For example, a woman may have a PAP done by a gynecologist but this information might not be forwarded to the primary physician. The same could be true for influenza immunizations which are done at community health centers or mammograms which are done at a mobile unit. However, in this study completion rates were no better for patients of the OPD, who generally have all services completed at MCD, in which case all results are included in the primary physician's chart. Finally, there could be errors in the process of data abstraction. However, a 10 percent subsample of charts were reviewed by a second reviewer, and showed good agreement for all outcome variables (data not shown).

There are also limitations to how the results of this study can be generalized. This study was done at an urban teaching setting,

and is not intended to represent the private practice setting. Also, the results cannot be generalized to women who are uninsured or who do not see a physician regularly. These women are likely to be at even higher risk of having inadequate preventive care, but are beyond the scope of this study. Finally, one cannot generalize from the preventive services examined in this study to all preventive care.

Despite these limitations, the findings of this study can have important implications for health policy. We know that preventive care in women is inadequate; one factor could be poor physician performance. However, caution must be exercised when using patient utilization as a proxy for physician performance.⁵ Since many factors are involved in whether a patient receives preventive care, physician performance should be assessed by measuring factors that are under physician control, such as physician recommendation. Where low levels of physician recommendations are found, then efforts can be made to target physician behavior. However, where patients fail to get preventive care despite their physicians' recommendation, targeting physicians is unlikely to be an effective strategy. It is important that inadequate utilization of preventive care is not falsely attributed to poor physician performance.

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Premenstrual Syndrome: Diagnosis and Treatment

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Abstract

Premenstrual syndrome (PMS), many physicians do not believe that the disorder exists. Numerous special interest groups also dispute its existence. There is still no clear consensus about the diagnosis of PMS. It is now a diagnosable disorder which can be effectively treated. This article describes the diagnosis, clinical features, and approach to management of PMS.

Introduction

The premenstrual syndrome (PMS) continues to be an enigmatic disorder. One of the first medical reports in the field is credited to Frank,¹ who coined the term premenstrual tension. Katrina Dalton, of the U.K., was among the first to raise wide awareness of this disorder among both the lay and medical community. This was followed by intense investigative efforts during the 1980s by numerous leaders in the fields of gynecology and psychiatry. The result of these efforts has culminated in recent years with the publication of several double-blind randomized clinical trials establishing the efficacy of numerous varied therapeutic approaches for PMS.

Despite these giant strides, PMS continues to be plagued by skepticism and contro-

versy. Many physicians do not believe that the disorder exists. Numerous special interest groups also dispute its existence. There is no clear consensus about the diagnosis of PMS and there is great controversy as to the basic nature of the disorder. While these debates continue to rage, the physician can take heart in the reality that the diagnosis of PMS can most often be made through a few simple diagnostic steps. Furthermore, numerous proven therapeutic approaches are now available. This is clearly more than can be said for many of the conditions which present to us on a daily basis. PMS is no longer a complaint to be dreaded but a diagnosable disorder with precise therapeutic interventions.

Definition and Epidemiologic Considerations

A sound knowledge of the definitions of PMS and the debate surrounding them is critical to gain an understanding of its clinical approach. Many definitions for PMS have been proposed over the years. These have come from the various fields of medicine, including reproductive endocrinology and psychiatry.

PMS is often defined as: "the cyclic recurrence in the luteal phase of the menstrual cycle of a combination of distressing physical, psychological, and/or behavioral changes of sufficient severity to result in deterioration of interpersonal relationships and/or interference with normal activities."² Nearly 200 symptoms have been associated with this definition and it is the clustering of these signs and symptoms which is the hallmark of PMS.

The American Psychiatric Association (APA) defines PMS in its diagnostic and sta-

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tistical manual (DSM). The term Late Luteal Phase Dysphoric Disorder (LLPDD) was introduced and more recently in preparation for the DSM-IV, this was changed to Pre-Menstrual Dysphoric Disorder (PMDD). The diagnosis of PMDD relies essentially on four elements confirmed through prospective daily self-ratings over two cycles.

While these definitions encompass a large number of patients presenting with PMS symptoms, there are numerous women whose symptoms fall outside of these definitions. One such disorder recognized for over 100 years, is catamenial epilepsy,³ with seizures either presenting only during the premenstrual phase or being grossly exacerbated at that time. The term catamenial is derived from the Greek and signifies around menses. In general, instances where a single recognized medical condition presented in the premenstruum were referred to as catamenial disorders while a cluster of symptoms was referred to as PMS.

Many patients with psychiatric disorders also complain of worsening of their symptoms around the premenstrual phase. This has led to the term Premenstrual Magnification (PMM). This concept was expanded and ultimately led to the proposal that all women with perceived PMS have an underlying psychological problem, which is the key to understanding their symptom. Patients who manifest their symptoms uniquely in the luteal phase fall in the PMS category while those that have an exacerbation of symptoms are classified under the PMM category. In each of these groups, patients are further divided based on the presence of severe psychological symptoms. Patients in the PMS group who meet these criteria have PMDD, which is therefore a sub-category of PMS.

It should be obvious by now that in the absence of a standard definition, the actual prevalence of PMS is difficult to establish. These have ranged between 5 percent and 80 percent. While many women are aware of changes which occur in their body during their menstrual cycle, this is usually not incapacitating and therefore does not constitute PMS. Using strict criteria, most authorities agree that the incidence of PMS is around 5

percent to 10 percent of women in the reproductive age range. Little data is available about ethnic or racial differences. Of great concern is the fact that there are great geopolitical differences in the recognition of PMS as a clinical entity. Europe presents interesting contrasts with the U.K. and the Scandinavian countries providing leadership in the investigation of the disorder while it is almost completely ignored in France, Germany and many other countries. Much work needs to be done to resolve these issues.

Etiologic Considerations

The timing of PMS suggested from the onset a link with ovarian hormone production. Early efforts concentrated on measuring circulating levels of progesterone, estrogens and the ratio of estrogen to progesterone. For years the idea that women with PMS suffered from a relative deficiency of progesterone and that supplementation with this hormone resolved the problem. Unfortunately, this hypothesis could never be confirmed through controlled studies either in terms of circulating hormone levels or therapeutic response to progesterone, as will be outlined below.

Several studies have looked at gonadotropin, ovarian and adrenal steroids in patients suffering from PMS. Overall, the studies have yielded contradictory results. However, if one takes into account the totality of the literature, including that relative to menopause, there is clear support for major effects of steroid hormones on CNS function, including behavior, mood and cognitive functions.

Numerous other areas have been investigated. These include thyroid hormone and thyroid stimulating hormone, prolactin, cortisol metabolism, glucose and insulin metabolism, vitamins, trace elements and electrolytes. No definite abnormality in any of these could be demonstrated.⁴⁻⁶

The most promising results thus far in elucidating the etiology of PMS have centered on neurotransmitters, particularly β -endorphins and serotonin. Studies on β -endorphins overall suggest lower levels in the peripheral circulation during the luteal phase in women suffering from PMS.⁷ This does not appear to be the case in cerebrospinal fluid.⁸ These puz-

zling and somewhat contradictory results need to be investigated further but there is clearly a suggestion of some dysregulation of the endorphin system in patients suffering from PMS.

Serotonin (5-hydroxytryptamine) is a rather ubiquitous neurotransmitter which is mostly synthesized in situ from tryptophan. Close to 90 percent of serotonin is found in the enterochromaffin cells of the GI tract while the remainder is found in platelets and the CNS. In the brain, serotonin is at the core of the dominant monoaminergic system and thus plays a key role in integrative functions including behavior, appetite, temperature control and hormone release. Because of its far ranging impact, serotonin is a natural candidate in the etiology of PMS. Several studies done on platelets have confirmed an abnormal uptake of serotonin during the luteal phase in women with PMS.⁹ Serum serotonin levels were also found to be lower during the luteal phase in women with PMS.¹⁰

In summary, it appears most likely that PMS is related to the interaction between hormonal events and specific neurotransmitters. Given the heterogeneity of patients with PMS and the wide range of symptoms, it is likely that many of these factors are involved. It is likely that women who suffer few neuropsychiatric symptoms demonstrate more of the hormonally mediated mechanisms while those with PMDD represent the other extreme, with major involvement of neurotransmitters.

Diagnosis and Differential Diagnosis

Studies show that 25 to 75 percent of women presenting with a complaint of PMS will be found to have another medical condition.¹¹ By far the most common mistake is to initiate therapy prior to formulating a differential diagnosis and obtaining prospective documentation of symptoms. PMS truly is a diagnosis of exclusion. Conditions which should be considered as part of the differential diagnosis are listed in Table 1.

Fortunately, most of the differential diagnosis can be considered and ruled-out through an accurate history and physical ex-

Neurological Disorders

Migraine/Seizure Disorders

Endocrinological

Hyperprolactinemia/Panhypopituitarism

ACTH-mediated disorders

Anorexia nervosa/Bulimia

Thyroid disorders

Hypothyroidism/Hyperthyroidism

Adrenal Disorders

Cushing's Syndrome/Hypoadrenalism

Pheochromocytoma

Hyperandrogenism

Breast Disorders

Gynecological

Dysmenorrhea/Pelvic Inflammatory Disease/

Endometriosis

Perimenopause

Gastrointestinal

Irritable Bowel Syndrome/Inflammatory Bowel Disease

Idiopathic Edema

Allergies

Chronic Fatigue States

Anemia/Chronic CMV infection/Lyme disease/

Other

Psychiatric/Psychological Disorders

Unipolar affective disorders

Bipolar affective disorders

Anxiety neurosis

Personality disorders

Substance abuse

Psychosocial problems: marital disorders

Table 1. Disorders to be considered in the diagnosis of PMS.

amination. This includes a detailed survey of prescribed and over-the-counter medications utilized. A family pedigree may provide clues to other individuals with affective disorders, attention deficit disorders, disorders felt to be linked to serotonin dysregulation or PMS. The physical examination should specifically rule-out thyroid disorders, breast pathology including galactorrhea, any evidence of Cushing syndrome and rule-out pelvic pathology, especially that compatible with endometriosis.

There is no confirmatory laboratory test for PMS to date. Routinely investigations are not required in these patients outside of those

recommended for periodic health examinations. One should however make liberal use of studies which are to be considered as part of the differential diagnosis. This includes thyroid function studies, search for anemia liver function tests and infectious surveys. The perimenopausal state can often mimic PMS and this should be entertained in the workup of these patients.

The key element in the diagnosis of PMS is the daily prospective recording of symptoms by the patient for at least two cycles. There are no substitutes for this approach and treatment failures are most often linked to a missed diagnosis from the onset.

Several instruments are available to achieve these results. The patient can simply keep a diary and these can be reviewed. This is often difficult and cumbersome to analyze. Numerous structured questionnaires and scales exist, such as the Moos Menstrual Distress Questionnaire (MMDQ) or the Patient Report of Increased Symptoms with Menses (PRISM). These can be complemented by the periodic administration of structured psychometric tools such as the Minnesota Multiphasic Personality Inventory (MMPI) or the Beck's Depression Inventory (BDI). Additional elements which can be tracked include basal body temperature and body weights. These instruments or a diary should be kept by the patient during treatment for three to six months. Since PMS symptoms usually fluctuate it may be prudent to discontinue therapy for two months to evaluate the patient off of therapy, but during this observation period the daily recording of symptoms should be continued to rule out any placebo effects.

With the advent of effective therapeutic regimens for PMS, the accurate diagnosis of the disorder becomes critical. Adequate consideration of confounding conditions is the first step. Prospective confirmation of the symptoms and signs of PMS is the next. A rational therapeutic plan may then be formulated.

Treatments for PMS

There are now a wide range of truly effective therapeutic approaches available. Unfortu-

nately, too many empiric treatments, many of which have now been shown to be ineffective, continue to be utilized. With a placebo response rate in patients with PMS ranges between 20 percent and 50 percent, it is essential that double-blind randomized trials be conducted to assess therapeutic effectiveness. Specifics of the study population must also be considered. Many studies conducted in PMS clinics run by psychiatry departments will have patients who principally have mood-related complaints while those performed by OB-GYNs will often include a large component of patients with mastalgia and pelvic pain. Therapy will be greatly affected by such factors.

The ultimate goal of the therapeutic intervention for either PMS or PMM is to either relieve all symptoms or to allow her to develop the coping mechanisms necessary to function evenly at all times.

General Measures/Lifestyle

Many are critical of pharmacologic therapy for PMS. They rather advocate lifestyle changes. Although interventions such as dietary and lifestyle changes may be helpful, one must realize their limitations. First, it is extremely difficult to establish their merit in a double-blind fashion, and these studies this far are largely lacking. Second, if one considers PMS to be a true medical disorder, such as hypertension and coronary artery disease, lifestyle modification should be viewed in the same context. While a few individuals can modify their diets and exercise to such an extent as to relieve or reverse hypertension or coronary artery disease, the majority of patients opt for pharmacotherapy. This is unfortunate but nonetheless a reality. Similarly, women with PMS should be offered the range of pharmacologic options currently available.

Lifestyle interventions which have gained support include structured exercise programs, increasing the intake of complex carbohydrates during the luteal phase as well as decreasing salt, refined sugar intake, and the benefit of supportive therapy.

Medical Therapies

Many patients with mild symptoms of PMS

require relatively innocuous therapeutic interventions, mostly targeted at their symptoms. The evidence for the therapeutic effectiveness of these approaches often draws from other areas of investigation, such as the management of periodic fluid retention or mastalgia.

There are many over-the-counter preparations available. The vast majority of these are nothing else than a combination of ineffective or minimally effective preparations for PMS. They usually combine a mild diuretic, vitamins and mild sedative preparations. Studies are currently under way to determine their effectiveness. The biggest problem with these preparations is that it encourages women to treat themselves without seeing a physician. With a disease that affects only 50 percent of people who think they have it, this is a major problem.

Calcium (1gm daily), magnesium and several multivitamin preparations have been advocated for the treatment of PMS. Stool softeners and bulk-forming agents can relieve symptoms of GI disturbance. Mild diuretics, such as spironolactone - 50mg daily, may help with fluid retention symptoms.

Non-steroidal anti-inflammatory drugs (NSAIDs) are extremely effective in the management of dysmenorrhea. Patients in whom this is a major component of their symptoms will benefit greatly from this form of therapy. Failure of one formulation should prompt a trial with another preparation rather than discontinuation of therapy.

There is much interest about a possible infectious component to PMS with effective therapy provided by doxycycline.¹² Many share the view that these cases actually represent women with sub-clinical pelvic infections who experience the recognized flare-up during the menstrual period. Work in this area is continuing.

Patients with PMDD

As outlined above, serotonin is a likely key neurotransmitter in the etiology of psychological manifestations of PMS (PMDD). Broad-scale studies have produced extremely encouraging results using the newly developed specific serotonin reuptake inhibitors

(SSRI). At least two of these agents can now be used clinically based on solid clinical trials: *Fluoxetine* (Prozac) and *Buspirone* (Buspar).

The Canadian Fluoxetine/Premenstrual Dysphoria Collaborative Study, in which 180 women completed the protocol, established the value of fluoxetine at a dose of 20mg per day which reduces the potential for side effects while maximizing therapeutic efficacy in the management of patients with PMS.¹³ *Buspirone*, in doses ranging from 2.5mg-5mg MD, has been documented to be effective.¹⁴ It can also be given on a continuous basis or with the onset of symptoms. Fluoxetine generally is used in patients who report depression or fatigue as their dominant symptom while buspirone is used in those instances where anxiety is a major component. While many SSRI are available, they are clearly not interchangeable. One should preferably await double-blind randomized trials before using the other agents in this family to manage patients.

A recent trial on over 170 women with severe PMS has confirmed that *Alprazolam* (Xanax) has a role in PMS treatment and offers therapy that can be limited to the luteal phase.¹⁵ The dosage ranges from 0.25mg TID to QID and the medication is given with symptoms. It is particularly helpful when agitation and anxiety form the dominant cluster of symptoms. It is estimated that up to 10 percent of women may develop symptoms of withdrawal, manifested by anxiety and restlessness, if the medication is stopped abruptly. In these cases, a progressive tapering regimen is indicated, going from TID to BID for two days and daily for two more days. Other centrally active agents which have been shown to be effective in some studies include clonidine and naloxone.

Patients with PMS or PMM

Hormonal therapies are best reserved for patients with PMS excluding those with PMDD unless they have concurrent symptoms which may be addressed by hormonal therapy. Patients with PMM are also candidates for these therapeutic approaches.

Oral contraceptives have generally not been effective in the management of these patients, though adequate controlled trials are lacking. Failure to improve on oral contraceptive does not rule out PMS, and many women persist with their PMS symptoms while on oral contraceptive preparations.

By far the most successful therapeutic hormonal agent in our practice for PMS has been danocrine. The dose utilized is 200mg daily. There are two regimens. One starts at the onset of symptoms and stops when the symptoms usually stop during menses.¹⁶ Another regimen consists of continuous therapy. This is a very effective form of therapy, particularly for any patient in whom mastalgia is an important complaint.

Progesterone was among the first therapeutic agents proposed for PMS. It continues to be widely promulgated and utilized. Unfortunately, all randomized double-blind controlled studies have failed to show any therapeutic benefits from vaginal progesterone therapy. Because of this, oral micronized progesterone therapy has become widely touted. A recent large-scale controlled trial again failed to show any superiority over placebo.¹⁵ Hopefully, this will finally put a halt to a clinical practice for which there is no experimental support.

There are isolated reports of high dose estrogen and testosterone therapy in patients with PMS. Therapeutic effect may be achieved by cycle suppression. Further investigations are mandated before this can be applied clinically.

Patients Who Fail to Respond to Standard Therapy

When all other forms of therapy have failed or in patients where patients' symptoms are severely incapacitating and near immediate intervention is necessary, long-acting gnrh agonists (LA-GnRHa) are highly effective.¹⁷ This is best reserved for use in rare instances and in experienced hands. Initiation of agonist therapy in the follicular phase may result in an acute flare-up of symptoms in some patients. Pregnancy must be ruled out if a period does not start within the expected time.

If one views PMS as directly linked to the menstrual cycle, bilateral oophorectomy should resolve the symptoms. Indeed, Reid et al has reported on over 100 women in whom a TAH-BSO was performed and where a cure for PMS was achieved.¹⁸ This should be viewed as a last resort and that with the advent of LA-GnRHa, an initial trial on these agents should be accomplished prior to surgery.

Conclusion

PMS continues to be a fascinating disorder. Recent developments have clearly established the necessary diagnostic steps. Effective therapeutic strategies are now available.

It is critical for the practicing physician to keep up-to-date in this rapidly evolving field. This growth of information presents a major challenge for all those trying to keep abreast of developments in the field. Nonetheless, progress has been occurring at an accelerated rate and the medical management of PMS can now be considered a major success story.

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Women Physicians in Delaware

Dene Walters MD

On thinking back to the time when I first came to Delaware in the mid-1950s, it seemed to me that an extraordinary number of women physicians were working here at that time. I wondered if their numbers were greater than in other communities and if so, why. Recently I decided to try to find out. This proved a more difficult project than I had expected.

The Medical Society of Delaware does not have any membership data from earlier than its first pictorial roster which was printed in 1972. The New Castle County Medical Society printed its first pictorial roster in 1962, but it was only for New Castle County. The Board of Medical Practice has logs of new licenses issued year by year as far back as 1895, but they didn't begin to keep a master list of all licenses until 1989, so it's impossible to reconstruct a list of physicians, men or women, who were here in earlier years but moved away, dropped out, etc., prior to 1989.

There are no staff records still in existence for any of the three Wilmington hospitals that became the Medical Center of Delaware prior to their merger in 1965. Interestingly too, the AMA has no files or lists dating to the time before they got every member listed on their computer in 1970. (I was surprised to find there are not even any files in a dusty basement in Chicago.)

By going through the Board of Medical Practice (BMP) logs I found that between 1916 and 1938, 13 women physicians were licensed in the state. Six of them were still practicing in 1956. (The six were Mildred

Forman, Margaret Handy, Edith Incababian, Catherine Johnson, Elizabeth Miller and Verna Stevens-Young). Between 1939 and 1956, 25 more women were licensed, but I could not get a figure for the total number of licensed physicians in Delaware in 1956. The BMP logs told me that from 1941 to 1950 there were 231 licenses issued, and only nine of them were to women (or 3.9 percent), but as these were new licenses only and women who were already practicing can not be counted. From 1951 to 1960, 19 more women were licensed out of a total of 325, which was 6 percent for that period of 10 years.

Nationally, the data (from sources other than the AMA, which of course would include MDs only at that time) show that the percentage of women doctors in the United States in 1950 was 6 percent. In the late 19th century it had been close to 5 percent, and reached 6 percent by 1910, but after that it gradually declined to 4 percent. This decline has been attributed to a variety of causes, but mostly it is thought it happened because men doctors were making it really tough for women who wanted to become physicians. The training of women was boosted again somewhat by WW II. Harvard Medical School took its first woman student in 1945; one of those women, Dr. Marjorie Kirk McKusick, came to Delaware to practice with Wilmington's John Maroney. Our neighbor, Jefferson Medical College, was the last U.S. medical school to accept women students, in 1961 (but they were the first to have a female Dean, in 1982).

Since 1950, as we all know, there has been a steady increase in women doctors all over the United States. By 1991 about 20 percent of physicians were women, and in that year women represented almost 39 percent of American medical students. Now in 1995-96 more than 50 percent of U.S. medical students are women.

But what about Delaware in 1955, '56 and '57 (the period I began with)? It appears to be impossible to say, for the whole state anyway. In the 1956 Wilmington telephone book there are 316 physicians listed. Among them there are 15 women (of these there are two who are not on my own memory list, Alice Berlin and Alva Parvis, as I did not know either of them at that time). They were: Alice Berlin, Alva Parvis, Margorie Conrad, Katherine Esterly, Mildred Forman, Phyllis Gallaher, Margaret Handy, Catherine Johnson, Wilhelmina Ley, Marjorie McKusick, Margaret Smith O'Brien, Bernadine Z. Paulshock, Ethel Platt, Margaret Richey, and Verna Stevens-Young.) There are nine more women not in the phone book who were either residents who stayed here to practice (Ruth Oartel and Joyce Anderson), physicians in Public Health positions or otherwise employed (Barbara Rose, Patricia Turner, Sarah Bishop, Louisa Mankin, Joyce Pearson), or were perhaps partially retired but still attending meetings and conferences (Elizabeth Miller). (MCD's department of Medical Education house staff records show some women interns and residents who were here for a year or two but then moved on, so I have not included them in any of these numbers of "practicing" women doctors.) Edith Incababian was practicing then and although I did not look at the DOs in the phone book, I am sure she was the only one.

My total for 1956, therefore, is 23 women. Since that 1956 phone book lists 316 physicians in all, I can make a fair estimate that about 7 percent of the doctors in Wilmington/New Castle County were women in 1956 (and yes, I'm not counting a few men doctors who were here but were not in that phone book). That's not as high as I thought would be the case when I started this project, but 7 percent

is a little above the national average for that time.

I never asked any of these women if they came here because they thought Delaware was more hospitable to women doctors than elsewhere. It seems to me now that the question is irrelevant, but had I found the percentage to be something startling, like 10 or 15 percent, I'd have wanted to ask it. There is no doubt however, that these women were, overall, an outstanding group, and Delaware was fortunate to have had them.

Acknowledgements

I am indebted to Dr. Norman Cannon for his advice and assistance. His memory was better than mine and he remembered all of the women I did and several more besides. Rosemarie Vanderhoogt at the BMP was very helpful and patient during my (and her) digging around in their archives. I would not have this in readable form without the help of my dear friend Bernadine Paulshock.

Also many thanks to Suzanne Melians, the librarian at the Medical Center of Pennsylvania Archives in Philadelphia, for her help in supplying me with valuable nationwide data.

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Golden Eggs

There is an Aesop fable about a man with a goose that laid golden eggs. The man eventually killed and dissected the goose in an effort to improve production, only to find that it was an ordinary goose inside. I suggest this may be analogous to Delaware and its DIMER program which has been laying golden eggs since 1970. The benefits are now taken for granted, and there are those who want to use the money for other purposes. Questions are raised. Why is there no audit? (There is annual accounting, and there has been Sunset review.) Solutions are being proposed for perceived shortages - the same solutions that have been tried all over the country for 50 years, and have consistently failed. We need to be very cautious how we change things lest we kill the goose.

For those not familiar with the DIMER program (Delaware Institute for Medical Education and Research), it is a contractual agreement involving University of Delaware (UD), the Medical Center of Delaware (MCD) and Jefferson Medical College (JMC), funded by the State of Delaware at about \$1.5 million per year. It was originally conceived as a temporary arrangement until UD could develop its own medical school, but it was never given the funds to do so, and UD's faculty rejected the concept, so for practical purposes it has functioned as an arrangement between MCD, JMC and the state. The MCD was to add salaried faculty and teach numbers of JMC students, and although the state has not provided funds for this, MCD has used other sources and fulfilled their part of the bargain. JMC for its part agreed to accept at least 20 Delawareans into each entering class on the same competitive basis it accepts Pennsylvanians and to give academic and educational support to MCD and the state of Delaware. JMC has complied fully. It is not likely that MCD could have recruited the strongly academic department heads and developed the successful residency programs it

has without JMC's backing. It is those residency programs which have provided, directly and indirectly, the major influx of excellent new doctors we have seen in the past 25 years.

DIMER is governed by a volunteer Board of nine persons, three appointed by the Governor, one from each county, three by UD and three by MCD. They receive no financial remuneration - not even travel mileage - and indeed it even costs them money to attend the meetings. There is nothing that specifies that any number should be physicians, and indeed over the years it has worked out at about half doctors and half what could be called "public" members. There are no offices and no staff, though for 20 years the MCD Director of Education has fulfilled secretarial or staff duties. Of the \$1.5 million appropriated each year, one million goes to JMC, about half the remainder to scholarships for the Delaware students (who pay their own tuition and expenses, about \$30,000 per year each) and the balance divided between UD and MCD. A token thousand goes to Delaware Academy of Medicine for administering the scholarships and additional loans which they provide from their own funds. The division of the small remainder between UD and MCD has never been the source of any contention, to my knowledge. They have willingly given up the scholarship portion out of compassion for the students, though nothing said they had to. The remainder is such a small part of what each institution puts into the program that they have not chosen to fight over it.

The DIMER legislation, which was a concept of E. A. Trabant then President of UD, was designed to address two problems: first, not enough Delawareans were able to get into medical school because everywhere they applied they were considered "out of state applicants," and second, without a widely recognized academic center in the state,

Delaware was not able to attract enough new physicians to meet its health care needs. All medical schools in the region were approached to evaluate their interest in participating in such a program. The schools in D.C. were too far away to be much help in supporting our institutions. Johns Hopkins and Penn were very polite, but they really had no interest. The three state related schools, Maryland, Temple and Hershey, couldn't participate because of conflict of interest. MCP and Hahnemann had the interest but lacked the resources. Jefferson was the logical choice.

It is difficult today to imagine the health care crisis that faced Delaware in the 1960s. There were less than 600 doctors practicing in the state, and too few new licensees to keep up with the losses by death and retirement. The medical residency programs in Wilmington, the usual source of new doctors, were ineffectual in recruiting candidates. A merger of the three largest hospitals in Wilmington to strengthen them, had not solved the problem. Things started to change with the JMC association. The number of new licensees went up from less than 30 per year to its present level of well over 200 per year. The number of doctors practicing in the state has more than doubled, with a 163 percent increase in Sussex County, 125 percent in Kent County and 102 percent increase in New Castle County.

It would be wrong, of course, to say that DIMER has been the perfect solution to all problems. One basic problem that has never been resolved is that the program is not widely known, at least not among those college juniors and seniors interested in medical school. It does no good to publicize it in high schools. Real interest in medicine is a mature judgement reached after careful thought, usually by the second or third year of college. Delawareans go to college all over the USA, and it would be impossible to follow up all of them, especially without any clerical staff. Another problem is a dearth of well qualified applicants. Our young people think of careers in business, engineering, chemistry, law, agriculture — but medicine is well down the list. Our state generates 35-45 applicants per year, and the bottom third could be looked on as high risk applicants, so the 20 going to JMC plus the small number getting into non-state related schools elsewhere, just about meet our needs. A major problem, of course, has been funding by the legislature. It takes

eleven years from high school graduation to entry into practice, and that's too long for voters to put together cause and effect. They accept the status quo as a given, and a major increase in funding for "some rich kids to get into medical school" does not garner many votes.

There are still spot shortages around Delaware, chiefly of primary care physicians. In most cases there are perfectly logical reasons for these, though some people would never be satisfied until there was a doctor going broke on every street corner. For example, in Kent and Sussex Counties, where over 50 percent of all newborns are Medicaid, and the Medicaid fee is set at 80 percent of cost (i.e. overhead and personnel) it is surprising that any obstetricians and pediatricians stay in practice. In some areas it has been tradition for family doctors to practice in their offices and specialists in hospitals. The new generation of very well trained family doctors does not see things that way. Even if it did make money, it is not as stimulating and rewarding. These things are changing, but it takes time.

There are essentially three approaches being proposed to solve these spot shortages. One is literally to "buy" doctors. A second would be physician extenders, essentially Physician Assistant and Advance Practice Nurses (PAs and APNs). The third, establish residency training centers in or near shortage areas.

1. Buying doctors takes any of several forms such as requiring DIMER students to come back (which will poison the DIMER program), special scholarship help, practice subsidy, paying off medical school debt, etc. All are temporary. The doctors tend to buy out or leave as soon as they legally can. It also antagonizes doctors already practicing in the area, and makes it difficult to attract anyone else without a similar incentive. It has been tried many times in many places and does not work.
2. Physician extenders are already being used. In general, PAs prefer to work closely with physicians, so the same standard of care continues. APNs prefer to practice as independently as legally possible and thus set up their own standard of care. Under Delaware law they must have a sponsoring physician, but they have a choice whether to consult him/her or not. At present UD trains APNs.

Strengthening their program might be a UD choice for their share of DIMER funds.

3. Residency programs must be approved by their appropriate accrediting agency. They do not approve rotations where the resident works without supervision, so a first step would be to hire a physician to act in that capacity. Another requirement is proper patient load such as an available hospital, suite of offices or clinic. Finally, the resident would need a place to live while on rotation. Ideally there should be some experience which the resident cannot get at the home base such as geriatrics, migrant farm workers, rural practice, etc. The recent merger of Kent General and Milford Memorial Hospitals might create a source of strength for such a rotation, as could a retirement community, Public Health Clinic or the vacation community in the Lewes-Rehoboth area. Existing accredited residency programs in New Castle County could form the base for such a rotation. DIMER funds could produce the seed money to start such a rotational program, but it would need the backing of the local physicians and probably some financial commitment from other sources.

Only a small portion of the doctors rotating through such an experience would ultimately settle in the area. Not everyone likes small towns, but with the troubles the cities are having, the small town life style looks better and better.

E. Wayne Martz MD, MBA

Note - At the time this was written the DIMER Board was composed of nine persons as noted. However, a bill pending in the General Assembly will raise that to 17, make it representative of several more specific constituencies and with a majority of lay members. Its function and responsibility of allocating the funds granted by the legislature will be taken over by the Governor's Health Care Commission, and the role of the DIMER Board will be advisory. The magical goose appears about to be dissected, and it will take 10 years to tell whether for better or worse.

— EWM



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IN BRIEF

Genetic Study of Anorexia Nervosa At Jefferson Gets Underway

A Thomas Jefferson University research team led by Wade H. Berrettini MD, PhD, professor of psychiatry and human behavior, are currently enrolling patients in a two-year study to identify genes that may contribute to anorexia nervosa (AN).

Recent medical research suggests that the risk for AN, in persons who have immediate relatives with AN, or other related eating disorders, may be six-times higher than the norm. The data suggest the possibility that there are one or more inherited genes that contribute to the rise of this illness.

During the next two years, Jefferson investigators, along with six other medical centers located throughout North America and Europe, will study 400 relatives to identify genes that may lead to AN. The researchers are seeking volunteers who have had anorexia nervosa, and who have a sister, brother or cousin who has an eating disorder, to participate in this two-year study. Participants will be compensated. Interested persons may call 215-955-0411 for more information.

Influenza in Delaware

Between late November 1995 and late January 1996, influenza A accounted for 100 percent of the isolates reported in Delaware. During February, there were no specimens submitted for influenza virus testing. Interestingly enough, the activity of influenza virus shifted from type A to type B during the February break. When the viral activity resumed in early March, Influenza B predominated in Delaware accounting for 75 percent of the isolates for the late season.

A similar pattern of influenza activity has been reported in the United States Influenza Update of late May, 1996. Between November 1995 and early January 1996, type A accounted for 80 to 100 percent of the isolates. Influenza activity declined substantially by mid-February and the ratio of influenza type A to type B began to change. By early March, type B predominated and between mid-March and mid-May increased to 76 to 100 percent of the isolates reported.

Thirteenth Annual CME Clinical Update in Pulmonary Medicine

The 13th Annual Clinical Update in Pulmonary Medicine will take place on December 7, 1996, at the Trump Plaza Hotel and Casino, Atlantic City, NJ. The course has been approved for 7 CME credits by the Medical Society of New Jersey and is accepted for credit by AAFP and AOA.

The curriculum is designed to provide physicians with a state-of-the-art review of pulmonary disorders commonly seen in a clinical setting and contains a balance between established standards of care and new methods and therapies in pulmonary diseases.

For more information contact Roberta Silver, Center for Bio-Medical Communication, Inc., Dumont, NJ 07628, or call (201)385-8080.

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Scientists need families for scientific research. There is an urgent need for families to help provide genetic researchers with the materials necessary to identify the genes that cause diabetes. Families can volunteer to be part of this research program to work with scientists, who have to date, identified five of the genes implicated in Type I diabetes. The Human Biological Data Interchange (HBDI), in partnership with the Juvenile Diabetes Foundation International and the National Disease Research Interchange, is a central resource supplying genetic researchers involved in the search for the diabetes genes with extensive family history and medical information from participating families. Families with two or more diabetic siblings are extremely valuable in the search for these genes. However, information collected from all families with diabetes is equally important in this effort. The success of this research effort is only possible with the participation of families with diabetes and the vast network of clinicians and other medical support staff who are willing to disseminate information about the HBDI program to their patients. Families or health care professionals willing to help may call or write:

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MSD MONTHLY ACTIVITIES

Working for You: May 1996

Leadership Activities

- Carol A. Tavani MD represented MSD at the MSNJ annual meeting in Atlantic City, N.J.
- Leslie W. Whitney MD and Mr. Mark Meister met with University of Delaware president, David Roselle, to discuss video teleconferencing technology for Delaware.
- Mr. Meister represented the Society at a meeting of the Medicaid Medical Care Advisory Committee.
- Charles L. Reese MD, Henry L. Weiner MD and Mr. Meister represented MSD at an organizational meeting of the Delaware Health Information Network.
- Michael Bradley DO testified on behalf of MSD's managed care legislation at a hearing in Dover convened by the Delaware Health Care Commission. Dr. Stephen Permut testified at the Commission's hearing in Wilmington.
- Drs. Tavani and Anthony Cucuzzella MD and Mr. Meister met with representatives of BCBSD to discuss the recently announced acquisition of BCBSD by Blue Cross of New Jersey.
- Dr. Tavani, Steven Edell DO, Paul Howard MD and Stephen Permut MD along with Phil Corrozi and Mark Meister met with Governor Carper to discuss managed care regulatory legislation.

Physicians' Advocate Program Activities

- Presented workshop "Successful Collection Techniques" in two locations.
- *Physicians' Advocate* and DMGMA sponsored the second part of their joint Coding Workshop. This all-day advanced coding class was taught by coding specialist, Barbara Kane, and attended by 54 people.
- The second annual EDI Expo was held on May 15th at the Clayton Hall Conference

Center at the University of Delaware. Over 115 people attended to learn more about the ever-changing field of medical office computerization.

- Presented "The Business Side of Medicine" to the Delaware Resident Section of the Medical Society at St. Francis Hospital.
- Presented a resident workshop in conjunction with the Medical Center of Delaware's Medical Education Program. The workshop focused on evaluating managed care contracts.
- Provided the following consultation services: 1) Consulting on practice management and accounts receivable to three area practices. 2) Taught an in-service on Front Desk Procedures to an office. 3) Provided confidential in-house consulting to three physicians.
- Developed plans for the start-up of an Employment Placement Service, through the *Physicians' Advocate Program*.

Credentials Verification Organization (CVO)

- Ongoing discussions with various hospitals and Managed Care Organizations regarding participation with CVO.
- Formed MCCO Steering Committee. First meeting scheduled for July 17, 1996.
- Continued negotiations with software vendors.

Continuing Medical Education Activities

- Sponsored 15 educational activities for Category 1 credit.

Other Activities

- The following physicians served as "Doctor of the Day" at Legislative Hall in the month of May: Michael Alexander MD, Rhoslyn Bishoff MD, Jason L. Campbell MD, Robert W. Frelick MD, Edward F. Gliwa MPH, MD, Jorge A. Pereira-Ogan MD, Julia M.R. Pillsbury DO.

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The *Delaware Medical Journal* is a monthly publication of the Medical Society of Delaware. The *Journal* reaches approximately 75 percent of the state's physicians, as well as medical libraries, and hospitals; its circulation is approximately 1,640.

Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting.

Closing for space reservations is the first of the month, two months prior to publication. Closing for materials is the first of the month, one month prior to publication.

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For a media kit or for more information, call Heidi Sigmund, assistant editor, at 302/658-7596 or 800/348-6800 (Kent or Sussex Counties).



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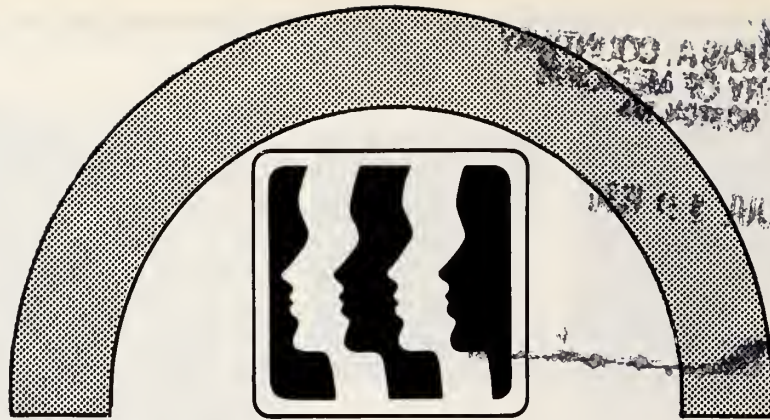


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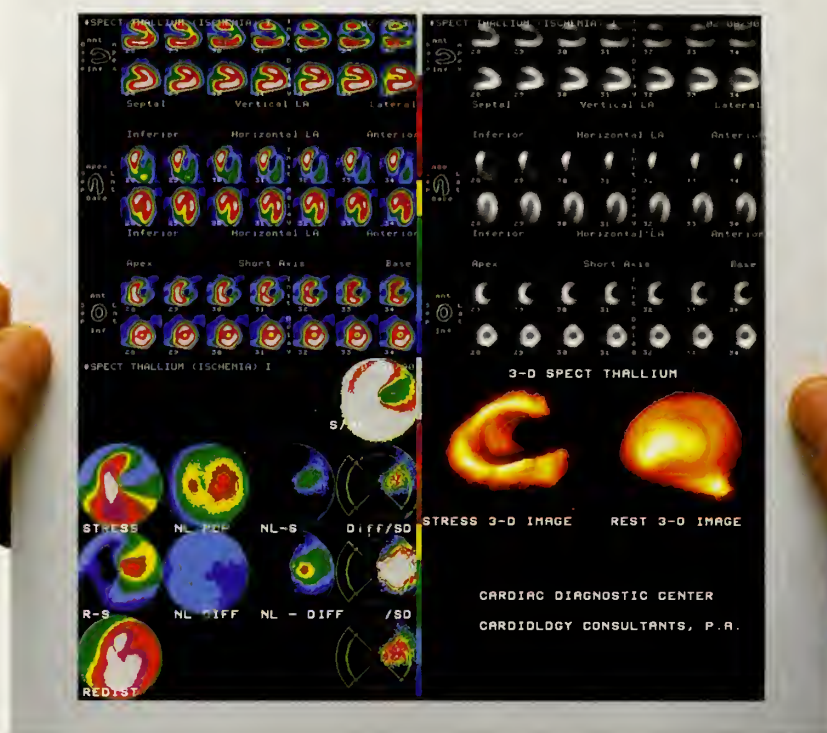
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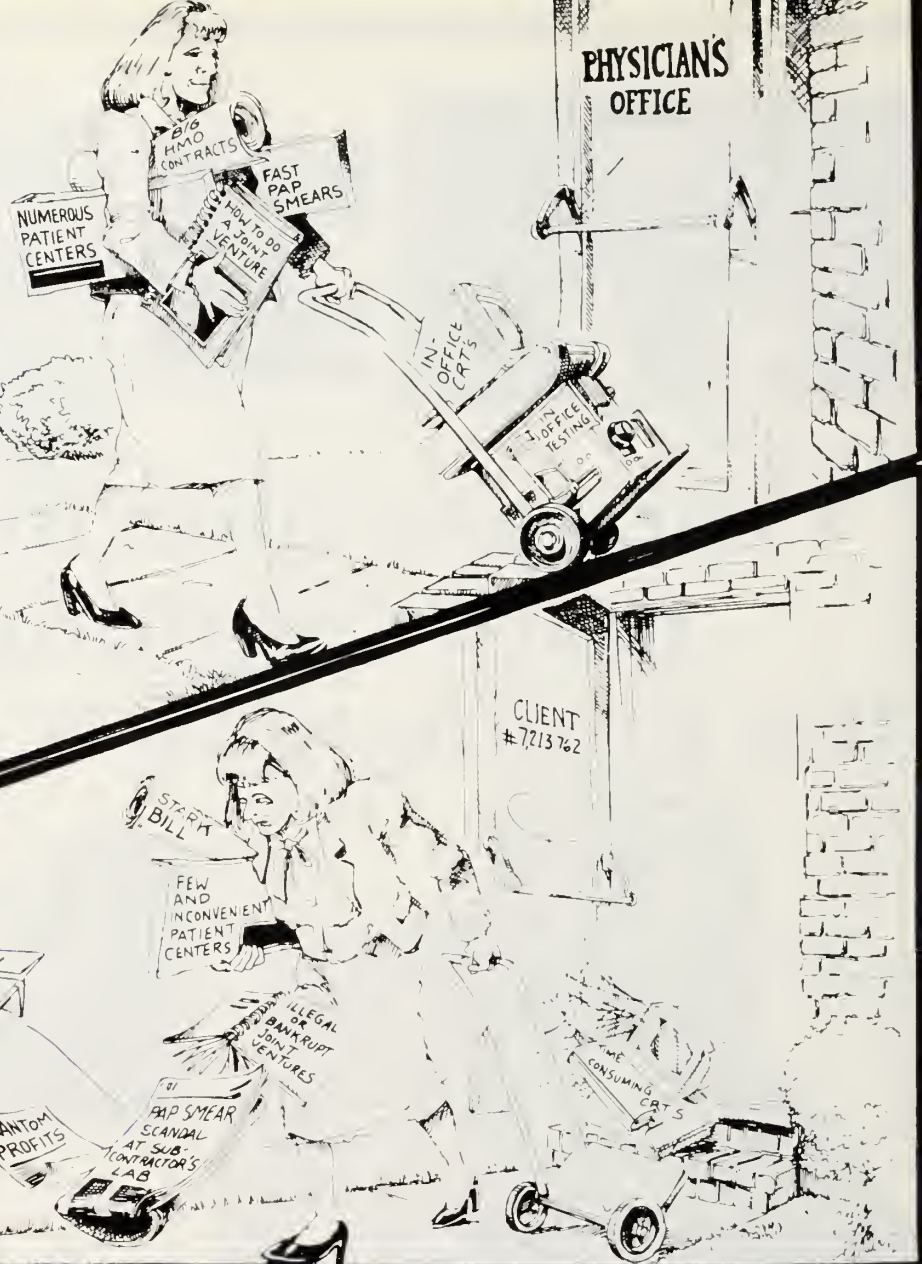
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The AMA Annual Meeting 1996: A Glimpse from the Floor of the House of Delegates

A more complete summary of the proceedings of the House of Delegates will appear in a forthcoming issue, but hopefully this brief overview will convey the breadth and complexity of the House's business, and exemplify the effort expended to serve its physicians and the patients they serve.

As might be expected, managed care occupied a prominent position in the discussions, with topics such as fighting gag clauses in HMO contracts, indemnification and hold harmless clauses, termination without cause, and alerting physicians to read and be aware of their contractual agreements being issues of major focus. Medicare reform, monitoring Medicaid Managed Care, concern about cut-backs in Medicaid for children and about mental health carveouts and parity merited lengthy dialogue.

Legislative efforts have long been a strength of the AMA and one of the arenas in which it best serves its membership. Medical liability reform, tort reform, ERISA modification, and CLIA requirements, as well as the fraud and abuse provisions in the House and Senate bills for health insurance reform (see last month's President's Page for details on this) are areas the leadership has been working long and hard on in Washington, and those policies and positions were carefully considered. The Data Bank, with regard to reporting of malpractice information and overruled disciplinary actions, was discussed.

Emerging issues concerning non-physician practitioners, their scope of activity, and our relationship with them were the subject of several resolutions.

New technologies, especially bringing the practice of medicine up to speed in the electronic data interchange environment, the computer-based medical record, confidentiality issues, and other automation-related material were especially interesting and relevant topics. AMA now has a legislative database, essentially a compilation of how each legislator voted on each issue, accessible on AMA's home page, as well as a legislative hotline with an 800 number (833-6354).

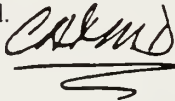
Many and varied coding issues were introduced for discussion, with support of correct coding initiatives for physicians. Likewise, credentialing issues saw lengthy consideration. The need for AMA collaboration with medical societies which operate physician credentialing services (such as the one MSD is currently incepting) was stressed. Societal issues, including domestic violence, handguns, boxing, HIV counseling, tobacco-related issues, and community health and primary and secondary prevention were considered from various perspectives.

Probably the single topic which received the widest media coverage was that of physician-assisted suicide, on which the House essentially reaffirmed its position that while the elimination or minimization of suffering may be one's goal, the elimination of life to end

suffering should not be. Related topics, such as honoring patients' organ donation intent, and the treatment of intractable pain, were also examined.

Medical education occupied a tremendous portion of the House's attention, as to its very preservation, as well as to updating that education to ready young physicians for the evolving climate of managed care and the ever-increasing complexity of ethical dilemmas. Considerations in the selection of residents were also posed.

Lastly, the very shape and face of the AMA remains a subject of paramount importance, because it is essential that the organization remain current, flexible, and fluid, so as to be responsive to those it represents. Given the size of this organization, that is no easy task. Much thoughtful consideration has been underway about how best to accomplish this, and how best to allow physicians to be represented with the identity that most closely suits or describes them. This is an ongoing effort about which your medical society will keep you apprised.



Carol A. Tavani MD



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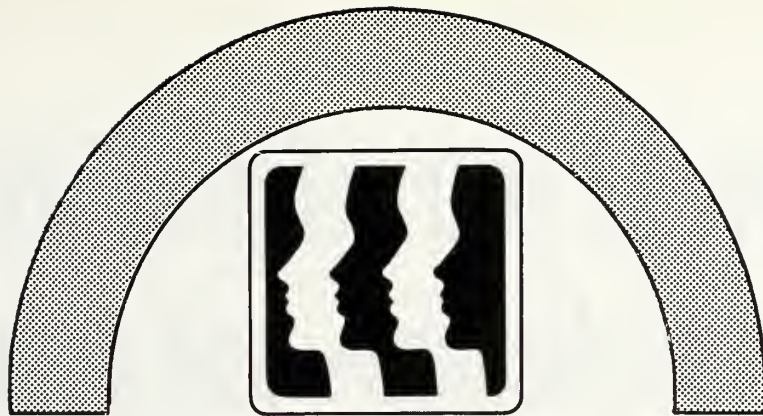
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Infectious Disease Pathology and Emerging Infections

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David A. Schwartz MD
Ralph T. Bryan MD

Since the 1970s, both the public health and medical communities have been called on to mobilize their combined resources in the investigation of a variety of newly recognized infectious disease threats (Tables 1 and 2). These have included Legionnaires' disease, Lyme disease, toxic shock syndrome, and diseases produced by viral agents of hemorrhagic fever, such as Lassa, Ebola, Marburg, Junin, Machupo, and Sabia viruses to name just a few. The advent of the worldwide pandemic of the acquired immunodeficiency syndrome (AIDS) introduced a vast number of previously unknown or rare opportunistic infections, which required new methods for diagnosis, treatment, and control. The past 20 years have also been witness to the resurgence of more familiar microbial threats, such as cholera, yellow fever, plague, anthrax, dengue fever, measles, diphtheria, and tuberculosis (Figs. 1 through 3).¹⁻³ As alarming as the increase of newly identified infectious agents is the emergence of recently developed patterns of antimicrobial resistance in common bacterial pathogens, such as the pneumococci and enterococci. These diverse groups of infectious diseases are characterized either by a dramatic increase in their incidence or by the threat of an increased incidence in the near future; they are referred to collectively as emerging infections. A variety of factors, acting independently or in combination, may influence the emergence or reemergence of an infectious disease. Examples of such factors include evolutionary or genetic changes in ex-

isting organisms, translocation of infectious agents into new environments or nonimmune hosts, and changing patterns of human exposure to environmental (e.g., food, water, or air), vector-borne, and zoonotic sources of infection.⁴⁻⁸

An important factor in the amplification of emerging infectious diseases as a worldwide threat to public health has been a pervasive sense of complacency toward infectious diseases in general by policymakers and health care professionals. This attitude has been partially responsible for serious breakdowns in surveillance systems, infectious disease control efforts, and prevention programs.^{1,2,9-11} Because of the dangerous deficiencies in the capability of national public health systems to diagnose and prevent outbreaks of emerging infections, these diseases are currently receiving renewed attention from international (e.g., the World Health Organization), federal (e.g., the US Public Health Service), and state health organizations (e.g., the Council of State and Territorial Epidemiologists and the Association of State and Territorial Public Health Laboratory Directors), as well as the medical and scientific community (e.g., the American Society of Microbiology and the Infectious Diseases Society of America).¹ In addition to increased interest from these professional organizations, the emerging infections have also become popular subjects for media coverage, not only including newspapers, magazines and television, but also novels and film.^{12,13}

Table 1.—Some Emerging Infectious Agents First Identified Since 1976*

Year Identified	Agent	Disease/Association in Humans
1977	Ebola fever virus	Hemorrhagic fever
1977	Rift Valley fever virus	Febrile disease, retinitis, fulminant hepatitis
1977	<i>Legionella pneumophila</i>	Legionnaires' disease
1977	Delta hepatitis virus (HDV)	Hepatitis associated with hepatitis B infection
1977	Hantaan virus	Korean hemorrhagic fever
1979	Ross River virus	Epidemic polyarthritis
1980	HTLV-1	T-cell malignancies, tropical spastic paresis
1982	<i>Escherichia coli</i> O 157:H7	Hemorrhagic colitis, hemolytic uremic syndrome
1982	HTLV-II	Hairy cell leukemia
1983	<i>Borrelia burgdorferi</i>	Lyme disease
1983	Hepatitis E virus	"Epidemic" non-A-non-B hepatitis
1983	<i>Helicobacter pylori</i>	Gastritis, duodenal ulcers, ?gastric cancer
1983	HIV-1	Acquired immunodeficiency syndrome (AIDS)
1985	<i>Enterocytozoon bienersi</i>	Intestinal and hepatobiliary microsporidiosis
1986	HIV-2	AIDS-like illness
1986	Porcine virus	Hemorrhagic fever/renal syndrome (HFRS)
1986	Human herpesvirus 6	Roseola (exanthema subitum)
1989	Barmah Forest virus	Polyarthritis
1989	<i>Chlamydia pneumoniae</i> (TWAR)	Respiratory infections
1989	Hepatitis C virus	Parenterally acquired non-A-non-B hepatitis
1990	<i>Hemophilus influenzae</i> biotype <i>aegyptius</i>	Brazilian purpuric fever
1990	Human herpesvirus 7	Lymphotropic virus, ? febrile disease
1991	<i>Encephalitozoon hellem</i>	Disseminated microsporidiosis
1991	<i>Ehrlichia chaffeensis</i>	Human ehrlichiosis
1991	Guanarito virus	Venezuelan hemorrhagic fever
1992	<i>Bartonella (Rochalimaea) henselae</i>	Bacillary angiomatosis, cat scratch fever
1992	<i>Vibrio cholerae</i> O139	New strain causing epidemic cholera
1993	<i>Septata intestinalis</i>	Intestinal and disseminated microsporidiosis
1993	Sin Nombre virus	Hantavirus pulmonary syndrome (HPS)
1993	<i>Balamuthia mandrillaris</i>	Leptomyxid amebic meningoencephalitis
1993	<i>Cyclospora cayentanensis</i>	Coccidian diarrhea
1994	<i>Ehrlichia phagocytophila</i> -like agent	Human granulocytic ehrlichiosis
1994	Human herpesvirus 8	Kaposi's sarcoma, body cavity lymphoma
1994	Sabiá virus	Brazilian hemorrhagic fever
1995	Equine morbillivirus	Pneumonia

* HTLV indicates human T cell leukemia-lymphoma virus; HIV, human immunodeficiency virus.

tions, and medical societies, the Centers for Disease Control and Prevention (CDC) has issued a strategic document that outlines plans for the revitalization of our national ability to identify, contain, and prevent emerging and reemerging infectious diseases.¹ Included in this document are recommendations for the reestablishment of core infectious disease pathology capability at the CDC and the development of cooperative training programs in infectious disease pathology. Unfortunately, despite having a significant role in the recognition and management of many emerging infections, the field of pathology has yet to systematically focus its attention on the problems posed by these diseases.^{9,16}

Examples of the valuable contributions of infectious disease pathology to the understanding of emerging infections are readily available. Infectious disease pathologists have been pivotal in elucidating emerging infections, such as bacillary angiomatosis/cat scratch disease, Lyme disease, cryptosporidiosis, ehrlichiosis, and numerous agents of viral hemorrhagic fever. Even neoplastic diseases, the classic bastion of

The threat that these infections pose to public health is so severe that three publications from the National Academy of Science's Institute of Medicine conclude that the ability of the public health and medical communities to control emerging infections is in jeopardy.^{2,14,15} In close collaboration with other federal and state agencies, scientific organiza-

anatomic pathologists, have fallen recently into the realm of infectious disease pathology with the recognition that human papilloma viruses, lymphotropic human herpes viruses, and Epstein-Barr virus are potential agents of carcinogenesis. The modern advances in infectious disease pathology have been due, in part, to the recent development of molecular

Table 2.—Previously Identified Zoonotic Agents, Which Since 1976 Are Emerging as Human Pathogens

Agent	Natural Host	Human Disease
Viral		
Junin virus	<i>Calomys musculus</i>	Argentine hemorrhagic fever
Machupo virus	<i>Calomys callosus</i>	Bolivian hemorrhagic fever
Dengue virus	Mosquito, human, monkey	Febrile illness/hemorrhagic fever
Influenza viruses	Fowl and pigs	Respiratory illness
Lassa virus	<i>Mastomys natalensis</i>	Lassa hemorrhagic fever
Monkeypox virus	Nonhuman primates	Smallpox-like disease
Marburg virus	Unknown	Marburg hemorrhagic fever
Yellow fever virus	Mosquito and monkey	Febrile systemic disease
Kyasanur Forest virus	Tick, rodent, and monkey	Encephalitis
Sindbis virus	Mosquito and birds	Arthritis, rash
Bacterial		
<i>Yersinia pestis</i>	Mammals	Plague
<i>Bacillus anthracis</i>	Herbivores	Anthrax
Fungal		
<i>Penicillium mamefei</i>	Bamboo rat	Disseminated mycosis
Parasitic		
<i>Encephalitozoon cuniculi</i>	Mammals and birds	Disseminated microsporidiosis
<i>Cryptosporidium parvum</i>	Mammals and birds	Diarrhea

when Ebola hemorrhagic fever was identified in Kikwit, Zaire in 1995,²¹ an important task of the site investigation team members was to procure infected human tissues for subsequent pathologic analysis. These specimens are currently

being studied and are contributing to our understanding of the pathogenesis and mechanisms of transmission of this lethal filoviral infection. In addition to viral diseases, current scientific efforts are also being directed toward a group of emerging protozoal infections, collectively termed

microsporidiosis. The three microsporidian species most frequently associated with disease in patients with AIDS (*Enterocytozoon, bieneusi, Septata intestinalis*, and *Encephalitozoon hellem*) have all been newly recognized and characterized since 1989 with the assistance of pathologists.²²⁻²⁵ In addition to these infections, pathologists have made significant contributions to our knowledge of the natural history of human immunodeficiency virus infection, as well as the numerous opportunistic infections associated with AIDS.⁹

The role of pathology in supporting national efforts to identify and control emerging infections is not in question. It is critical that pathologists become essential members of any organized program to address emerging infections. Pathologists at the community, state health department, or university levels are often among the first health care professionals to encounter novel infectious agents or new manifestations of known infectious diseases. As anatomic and clinical pathologists, and especially autopsy prosectors, they are invaluable in obtaining and evaluating valu-

pathologic tools, including nucleic acid hybridization, Southern and western blotting, restriction fragment length polymorphism analysis, and the polymerase chain reaction.¹⁶

The importance of anatomic pathology and laboratory diagnostic support for epidemiologic investigations has been highlighted by numerous outbreaks of emerging infectious agents that have occurred during the past three years. For example, pathologists were closely involved in the 1993 outbreaks of *escherichia coli* O157:H7, cryptosporidiosis, and hantavirus pulmonary syndrome, which collectively resulted in hundreds of thousands of affected persons as well as some loss of life.^{9,17} Infectious disease pathologists were instrumental members of the multidisciplinary scientific teams that identified, and subsequently produced specific diagnostic molecular reagents for, a previously unrecognized hantavirus as the etiologic agent in the epidemic of pulmonary disease and sudden deaths that began in 1993 in the southwestern United States.¹⁸ Early in this epidemic, closely coordinated efforts by public health investigators, scientists, and forensic and infectious disease pathologists were critical to the successful identification of the etiologic agent, the Sin Nombre virus, and the subsequent detailed description of tissue pathologic changes and anatomic distribution of virus.¹⁸⁻²⁰ Because of the valuable contributions from pathologists to this investigation,

currently being studied and are contributing to our understanding of the pathogenesis and mechanisms of transmission of this lethal filoviral infection. In addition to viral diseases, current scientific efforts are also being directed toward a group of emerging protozoal infections, collectively termed microsporidiosis. The three microsporidian species most frequently associated with disease in patients with AIDS (*Enterocytozoon, bieneusi, Septata intestinalis*, and *Encephalitozoon hellem*) have all been newly recognized and characterized since 1989 with the assistance of pathologists.²²⁻²⁵ In addition to these infections, pathologists have made significant contributions to our knowledge of the natural history of human immunodeficiency virus infection, as well as the numerous opportunistic infections associated with AIDS.⁹

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able samples of tissue for histopathologic, microbial, and molecular analysis.^{9,16} Submission of such specimens to infectious disease pathologists, for highly specialized diagnostic evaluations forms an important avenue of communication between pathologists, epidemiologists, and scientists.

The current shortage of expertise in infectious disease pathology in government and academic service, and the absence of even a single formal training program or fellowship in this subspecialty, raises important questions.^{9,16} First, how will the current critical shortage of infectious disease pathology expertise affect our ability to respond rapidly to the certainty of new infectious threats to public health? And second, how do we as pathologists resolve the many years of neglect in this specialty area and find solutions to assure the public at large, and the medical community in particular, of a supply of physicians trained in infectious disease pathology to support diagnosis, teaching, and research into the emerging and reemerging infections of the future? The answer may be to support the recommendations put forth in the CDC's strategic document on emerging infections by pursuing the development of a formal training program in infectious disease pathology.^{1,9} Because of the concentration of suitable faculty members in governmental and academic centers, an optimum arrangement might be a collaborative, or joint, training program, using established infectious disease pathologists supported by medical scientists and epidemiologists from university and governmental institutions located in the same region or city. These types of relationships already exist and are successful in other areas of postgraduate medical training.

The current focus on emerging infections by the journals of the American Medical Association highlights the importance of treating these threats as challenges to public health and medical care that have not and will not go away.²⁶ This issue of the *Archives of Pathology and Laboratory Medicine* is an appropriate and very welcome first step by the pathology community in addressing these challenges. The articles published in this special issue provide superlative examples of the

diversity of methods that medical and veterinary pathologists, microbiologists, and laboratory scientists are using to investigate the pathologic aspects of a wide variety of emerging infections. All of the major groups of emerging infectious agents (viral, bacterial, protozoal, and fungal) are represented in this issue.

It is clear that the future of infectious disease pathology lies in the continued development of molecular reagents for microbial diagnosis, which the current and new generation of pathologists will apply to a variety of clinical illnesses and outbreak investigations using specimens from both living and deceased patients.^{9,16} Although tissue specimens obtained using biopsy or cytologic techniques are useful for immediate evaluation of an infectious disease, the role of the autopsy should not be neglected. Within the specialty of infectious diseases, underuse of the autopsy has occurred in spite of its documented value in the diagnosis of undetected infections and in providing increased knowledge of the pathogenesis of disease.^{9,27,28} With the advent of the AIDS pandemic and newly emergent and reemergent infections, the necessity for autopsy-based studies has never been greater. In this issue, Zaki and colleagues²⁹ use immunohistochemical methods to identify a newly described hantavirus, the Sin Nombre virus, in archival autopsy tissues obtained from persons dying of unexplained noncardiogenic pulmonary edema up to 15 years before the initial 1993 outbreak. Their study provides an excellent example of infectious disease pathologists using immunologic and molecular methods for retrospective evaluation of archival formalin-fixed tissues, thus linking the emerging infections of today with yesterday's idiopathic illnesses.

The autopsy is also a useful, but underutilized, tool for the thorough tissue examination of persistent infectious agents in those patients whose emerging infections have been treated with trials of novel medications. In a brief report of a patient with microsporidiosis who responded to treatment with albendazole and became asymptomatic prior to death, Joste and coworkers³⁰ illustrate how the results of postmortem examina-

tion can confirm the eradication of microorganisms.

Surveillance is the single most important tool for the identification of infectious diseases that are either emerging, diminishing in significance, or causing serious public health problems. It has been estimated that the surveillance system in the United States has deteriorated to the level that several thousand cases would have to occur for a community-wide outbreak of a diarrheal illness in a municipal area to be detected by public health authorities.³ One method for improved surveillance of emerging infections is the use of the autopsy in cases of unexplained death, especially in young persons dying from fever of unknown origin, meningitis, encephalitis, myocarditis, gastroenteritis, or pneumonia.⁹ The value of the autopsy in the investigation of outbreaks of emerging infections was recently demonstrated by the role of the Office of the Medical Examiner in New Mexico in identifying the initial patients dying from hantavirus infection in 1993. In their commentary, Nolte and colleagues³¹ address the potential role of forensic pathologists and the autopsy in the recognition and investigation of emerging infectious diseases.

Three articles in this issue [*Archives of Pathology & Laboratory Medicine*, Feb. 1996, Vol 120, No. 2] are from investigators at the United States Army Medical Research Institute for Infectious Diseases (USAMRIID).³²⁻³⁴ The infectious agents discussed in these papers [*Archives of Pathology & Laboratory Medicine*, Feb. 1996, Vol 120, No. 2], *Yersinia pestis*, Ebola virus, and Venezuelan equine encephalitis virus, represent geographically disparate diseases that are of great concern to public health workers throughout the world. Using the rhesus monkey model, Jaax and colleagues³³ have demonstrated that a lethal infection by Ebola-Zaire (Mayinga) virus can be experimentally transmitted via the oral and conjunctival route of inoculation, adding to our knowledge of possible mechanisms for human infection. Davis et al³² describe the comparative pathology of F1-positive and F1-negative strains of *Yersinia pestis* in African green monkeys, and test whether immunohistochemical procedures can differentiate these

two strains in tissue sections.³² Vogel and co-workers³⁴ demonstrate how immunohistochemical and in situ nucleic acid hybridization methods can be used to demonstrate the route of entry of Venezuelan equine encephalitis virus into the brain of mice experimentally infected via aerosol and subcutaneous routes. These articles [*Archives of Pathology & Laboratory Medicine*, Feb. 1996, Vol 120, No. 2] emphasize the important contributions that have been made by veterinary pathologists, microbiologists, and laboratory animal medicine specialists using animal models to study the pathogenesis of emerging infections.

In addition to anatomic pathologists, clinical pathologists and microbiologists are essential members of the team approach for the investigation of infectious disease outbreaks and emerging infections. In the area of clinical pathology, laboratory examination of stool for routine and, especially, emerging microbial agents is becoming an increasingly requested diagnostic technique. However, in the current financial climate there is growing pressure for clinical laboratories to decrease costs and increase efficiency while maintaining high diagnostic standards. Valenstein and colleagues report the results of a College of American Pathologists Q-Probe study to examine the efficiency with which physicians at 601 participating institutions utilize routine stool microbiology tests, and make recommendations for cost-effective stool testing for bacterial and parasitic pathogens.³⁵

Although recent media and public attention have been largely directed toward the emerging viral diseases, protozoal infections are an increasingly important public health problem throughout the world. Microsporidian infections are being diagnosed with ever-increasing frequency in patients with AIDS and have recently been found to occur in nonhuman immunodeficiency virus-infected transplant recipients and travellers. The clinical and pathologic features of these microsporidian agents are being described with such rapidity that many pathologists are unaware both of the histologic, as well as the immunologic and molecular, methods for diagnosing these infections. In this issue,

Schwartz and colleagues³⁶ describe and illustrate the enlarging spectrum of clinical and pathologic changes due to microsporidian infections in patients with AIDS, and explain the role of electron microscopy, immunohistochemistry, tissue culture, and molecular pathology in the diagnosis of these agents. In another article, Albrecht and coworkers³⁷ in Germany describe their collective experience with leishmaniasis as an emerging infection in patients with AIDS treated in a nonendemic area. This communication brings up several important issues, including the importance of maintaining an index of suspicion for the pathologic identification of unusual or exotic infections in countries where the agents are not endemic.

Although no formal training programs have existed for infectious disease pathology, many of today's specialists acquired part or all of their expertise at the Armed Forces Institute of Pathology (AFIP). Nelson and colleagues³⁸ review some historical aspects of infectious disease pathology at the AFIP and discuss the institution's current efforts to support research and diagnosis of emerging infections.

The authors will consider this special issue a success if it stimulates our current and future generation of pathologists to request that educational and training opportunities become available in infectious disease pathology, so that they may be prepared to contribute to the future challenges of emerging infections, which are certain to arise. ■

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EXECUTIVE SUMMARY



M C S I

Managed Care Strategy Initiative

Introduction and History

This project technically began approximately two years ago when the long range planning committee of the Medical Society of Delaware (MSD) recognized the need to take a closer look at managed care and its potential impact on the State of Delaware. A Steering Committee was formed chaired by Anthony Cucuzzella MD and consisting of Michael J. Bradley DO, William B. Funk MD, Stephen S. Grubbs MD, Paul E. Howard MD, and Carol A. Tavani MD. After reviewing the approach taken by several other state societies, the Steering Committee was particularly attracted by the method employed in Pennsylvania. A site visit to the Pennsylvania Medical Society (PMS) occurred in January 1996. This resulted in a written proposal from PMS to MSD outlining a format for assisting MSD in its efforts. This proposal was accepted and the project officially commenced on March 18, 1996, when a "kickoff" dinner was held. At that meeting PMS and its subsidiary, PennMed Member Services

Company (PMSCO), presented their plan entitled a "Statewide Managed Care and PO Development Strategy." Three days prior to that event, Mr. James H. Wilton was retained to direct this project for the Medical Society. At this initial meeting it was determined that the Steering Committee needed a wider physician base and invitations were extended to 17 additional physicians. Fifteen of these physicians accepted and are currently serving on that committee. It was also at this time that the project was named "Managed Care Strategy Initiative." Steering Committee meetings were held monthly and updates and consultation occurred with the chairman on at least a weekly basis throughout the project.

Purpose

The purpose of the undertaking was to develop a comprehensive strategy with recommendations for the Medical Society of Delaware to assist Delaware physicians to

capitalize on opportunities arising from the managed care market and to help position physicians to most effectively transition into a managed care market in a way that both preserved the quality of patient care and maintained the integrity of medical care delivery.

Method

The initial phase of this project consisted of data collection. Numerous government and private agencies and associations were contacted in an attempt to gather as much demographic information as possible. This was concluded by the Delaware staff and forwarded to PMS within the first few weeks. Concurrently, interviews were scheduled with approximately 60 individuals throughout the state who had been identified by the Steering Committee as representative key players in the system of healthcare delivery in Delaware. These representatives consisted of physicians,

hospital executives and board members, employers, association directors, regulators, and insurance company executives and practice managers. In all, the project staff held approximately 51 meetings and spoke with approximately 73 people over a six-week period.

The information collected was reviewed from several strategic viewpoints. It was analyzed from a statistical viewpoint. It was also reviewed from the various viewpoints of the stakeholders. Finally, it was considered from the perspective of special interests that may exist.

Key Findings

Physicians

Sample

The population surveyed consisted of 19 non-Steering Committee physicians. Of these, 11 were from New Castle County and 8 were from Kent and Sussex counties. Six of the physicians interviewed were hospital employed. Three were vested in existing physician organizations of some type.

Results

The general consensus throughout the state is that managed care is going to prevail and that physicians must be prepared to assume risk. The overall impression was a strongly reactive posture. There is the feeling of impending change and a sense of fear due primarily to uncertainty and a sense of lack of control. The physicians feel unprepared for this event and express a need for some kind of unification or organization. The suggested solutions

varied from messenger model IPAs to unionization. This fact, coupled with the hospitals' fear as later delineated, helps to explain the presence of initial formation of such vehicles as Physician Hospital Organizations (PHOs). Physicians were almost unanimous in requesting education from MSD. There was also unanimous agreement to the proposition that medicine is local/regional in nature. Finally, it was agreed that the "window" of opportunity exists now and is limited.

Hospital Executives and Board Members

Sample

The executive and, in some instances, board members of 3 upstate and 4 downstate hospitals were interviewed.

Results

The hospitals are all working hard to make the adjustments necessary to survive in a managed care environment as they see their primary revenue source (hospital days) declining. Their strategies have included first the ownership of ancillary services such as SNF, home health, free-standing surgery centers, urgent care facilities and durable medical equipment. Secondly, many have purchased primary care practices ostensibly in a strictly defensive purpose. Finally (and most importantly for our purposes), they have made great efforts to concretize the relationship with their staff physicians through the PHO mechanism. These are presented as cooperative and equal efforts. They emphasize a "pro-provider" concept trying to closely align physician interests with their own. Some see MSD as a possible intermediary between them and their staff and perceive it as a threat.

Practice Managers

Sample

A total of 7 practice managers from both upstate and downstate practices were interviewed. Several were from large group practices and are leaders in Medical Group Management Association (MGMA).

Results

The silent scream from the practice managers was like that from a drowning swimmer. With managed care they see their overhead growing, staff needs growing, and an adversarial relationship developing with the Managed Care Organizations (MCOs). They see managed care impacting quality of care and denigrating physicians. They sought our aid wherever we might help.

Associations

Sample

The executive officers of some leading professional associations or trade groups were interviewed.

Results

There is a general sense that coalition is the only way for association members to be effective. This is similar to the trend of physicians organizing in an effort to be heard. This probably marks a general trend amongst allies in an ever-changing, unpredictable and somewhat frightening marketplace. They see MSD as another interested party representing its constituency and suggest that this might make it difficult for MSD to be a standard bearer.

Employers

Sample

The executive or benefits manager of 7 major employers met with us to discuss their thoughts regarding managed care.

Results

While employers vary in some attitudes depending on size and location, they were in agreement that health care cost is a major business issue. Some expressed the desire for value, which they defined as added benefits with the same or reduced costs. Other stated that quality was more important than price. Still others stated that the only criteria for the selection of a plan is cost. Some were very physician friendly, while others felt physicians were the enemy and couldn't evoke much sympathy. A major concern for employers is wellness and preventive medicine, which they were not sure was being delivered as promised from MCOs.

Regulators

Sample

We met with personnel from 3 key governmental offices to discuss managed care.

Results

The message from regulators was somewhat inconsistent. In one breath we were told they want to insure to access, prevention, and contain costs, while in the next they said it is necessary that some people get a Cadillac plan and others a Chevrolet. One thing was apparent. No one is regulating Managed Care Companies (MCOs) for any purpose other than contract review and solvency and there is no apparent plan to do so.

Insurance Companies

Sample

Executives from 5 insurance companies met with our representatives.

Results

The companies were cautiously polite. They are quite resistant to delegation of some of the critical functions, such as health services (utilization management, quality assurance and improvement). They desire for physicians to have access to HMOs and for patients to have access to physicians.

Others

Those who were vested in potentially competing enterprises were varied in their response. Some threatened, some tried to overwhelm, some reasoned about messing up the market. It was apparent that each hopes to see its current market share grow. They see any entry by MSD into the marketplace as both challenging and formidable due to the credibility enjoyed by MSD.

- "A consultant cannot be a consultant to both the hospital and the physicians."
PHYSICIAN
- "Health care never had to be a business before, this is a real problem."
HOSPITAL EXECUTIVE
- "We must fight off managed care as long as possible."
HOSPITAL BOARD MEMBER
- "Health care is like a public utility."
MAJOR EMPLOYER
- "No one is smart enough to manage the wrong group of doctors."
OTHER EXECUTIVE
- "Within two years Medicare will direct contract with delivery systems."
OTHER EXECUTIVE
- "Cannot understand why any downstate MD would be in a PHO. It is one payor mode, they are sole negotiator with third party, all end up as salaried from hospital in a one horse town."
OTHER EXECUTIVE

Cluster Comments

- "With managed care everyone who walks in the door needs a phone call."
PHYSICIAN
- "We can no longer practice medicine the way we were trained to do in the 1960's."
PHYSICIAN
- "We're poorly educated for managed care and we're scared."
PHYSICIAN

Issues

1. Is there a need amongst the physicians in Delaware for a formal on-going effort to assist, counsel and advocate for them in the managed care arena?
2. What activities are most needed and should the effort engage in?
3. What form should this effort take and how comprehensive should it be?

Summary Results

- In all areas of the state, among all constituency groups, there is a marked lack of knowledge about managed care principles.
- A major thrust in all comments was support for a collaborative approach among all stakeholders to managing future healthcare delivery in Delaware.
- While managed care penetration is high, there appears to be balance in the system stemming from large employers who are focused on managing cost, but are "philosophically driven," not "financially driven."
- Reimbursement is moving toward capitation and risk sharing, but there are varying levels of understanding of these concepts and varying levels of support for this progression among all parties.

Recommendations and Strategy

Physician Organization Development/Enhancement

The Medical Society should develop the capacity to assist in the formation and/or enhancement of medical care delivery models on a local/regional level. At the same time, it should develop the full capability to provide all technical and operational support to these models once they become operational.

Constituency Relations

The Medical Society should strive to influence the pace and direction of changes to health care delivery in the state through consensus building amongst regulators, employers, other payers and providers.

Education and Networking

Education is the most immediate need in Delaware and will be vital to the success of the managed care strategy initiative. The Medical

Society must take an aggressive, unprecedented approach to meeting this need with various constituencies.

Legislation and Regulation

The Medical Society should work to improve/expand managed care organization data reporting requirements and to define criteria for acceptable risk-sharing relationships. There is a distinct lack of oversight for industry activities in Delaware. At the same time, the Medical Society must take a leading role in preserving and safeguarding "the practice of medicine" as various interest seek to dominate or regulate medical care delivery. The Medical Society must be vocal in protecting the physician's role as care-giver and patient advocate.

Communications and Product Development

Medical Society publications should give prominence to managed care initiatives. Likewise, the allocation of resources for member services should focus on physician organizations and products that will reduce office overhead expenses as physicians feel more pressure to maximize efficiencies.

Medical Society of Delaware
Managed Care Strategy Initiative

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RADIOGRAPH OF THE MONTH



Figure 1. 1 cm enhancing medial temporal lobe lesion.

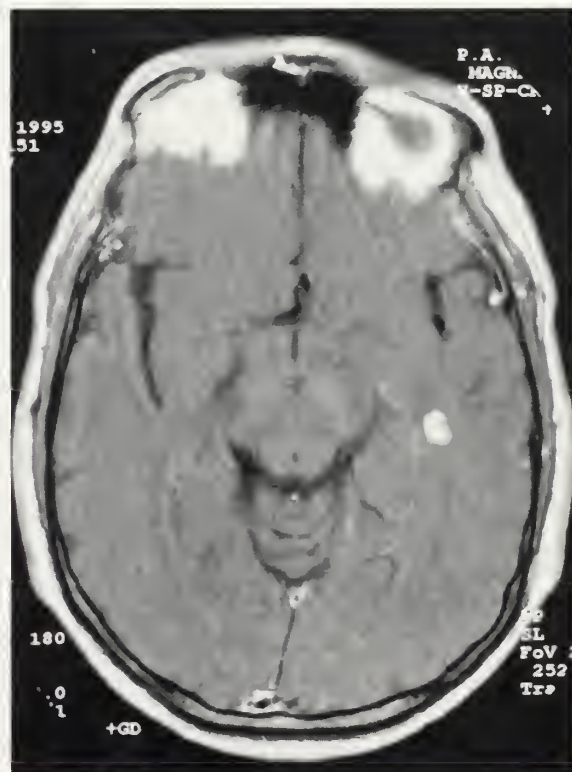


Figure 2. Markedly enhancing 1 cm medial temporal lobe lesion showing a small defect on the lateral aspect following stereotactic biopsy of lesion.

A 38-year-old man complaining of headaches and right-sided weakness. Patient had a work-up which showed he was HIV negative. Cervical spine MRI showed central disc herniation at C-5/6 and borderline Chiari I malformation. MRI of the brain is shown in Figure 1.

Pilocytic Astrocytoma

Bikash Bose MD

The glial cells, derived from the primitive spongioblasts, are the principle supporting cells of the brain. In terms of neoplasia, these give rise to gliomas, which, as a group, are the most common brain tumors (about 40 percent). They range from the extremely malignant spongioblastoma and glioblastoma multiforme to the relatively benign and slow growing astrocytoma (about one third of all gliomas). One uncommon variant of the astrocytoma, known as the pilocytic, shows a dense network of protoplasmic, fibrillary and pilocytic astrocytes with attachments to blood vessels characteristic of astrocytes in general. These tumors are often well circumscribed, and if so may be completely excised. They have a tendency to cystic change, and when this is so, have a favorable prognosis with up to 95 percent survival after 25 years. Their growth pattern is neoplastic (similar cell type) rather than hamartomatous (variable cells, some outstripping others). A small percentage of pilocytic astrocytomas may undergo malignant change to the more dangerous glioblastoma or primitive spongioblastoma with multicentric spread.

Pilocytic astrocytomas occur principally in the first two decades of life, but may occur at later ages. A large portion of these are cerebellar where they are often cystic. They also occur in the cerebral hemispheres, both solid and cystic, and in the hypothalamus where the prognosis is less favorable. Occasionally they are in surgically inaccessible areas, such as the optic pathways, or in the region of the third or fourth ventricle, where they have a distinctive morphology.

In the juvenile form these tumors may remain silent or static for many years, but eventually become symptomatic depending on their location. Diagnosis is usually not difficult with present day imaging techniques, and the tumors are readily demonstrated with appropriate contrast materials. Treatment is by excision when accessible. A few authorities advise radiation when the tumor cannot be completely removed, but most feel there is no evidence that this yields better results or longer survival. When they are inaccessible, they are treated by radiation or chemotherapy; but because they are uncommon, it is difficult to accumulate a large enough series to give statistical validity to this approach.■



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E. coli Now a Reportable Disease in Delaware

The number of outbreaks of *E. coli* 0157:H7 infection reported to the Center for Disease Control & Prevention (CDC) has increased dramatically in the last five years. Infection occurs by ingesting the organism, usually through contaminated food products, such as undercooked meat or unpasteurized milk. Other outbreaks have implicated contaminated apple cider, drinking unchlorinated municipal water, person-to-person transmission in day care centers, and swimming in a contaminated lake. *E. coli* serotype 0157:H7, designated by its somatic (O) and flagellar (H) antigens, is a toxin producing serotype that produces bloody and non-bloody diarrhea. Occasionally, the initial infection is followed by much more severe complications related to the toxin's entry into the circulation, such as hemolytic-uremic syndrome (HUS) or thrombocytopenic purpura, and sometimes death. These syndromes are most likely to occur in children or in the elderly.

E. coli 0157 is now a reportable disease in Delaware. The Public Health Lab can now electronically report isolates directly to CDC through PHLIS, the Public Health Laboratory Information System. Any labs that identify & serologically confirm their own isolates should notify Public Health through the existing "Disease Report Form" that should currently be utilized in all hospital and private labs in this state. Since this is a newly reportable disease, the information should be handwritten. Any questions related to this form should be directed to Dave Wolfe, Epidemiologist, 739-5617.

REVIEW OF LABORATORY DETECTION & IDENTIFICATION OF *E. COLI* 0157

The screening of fecal specimens for *E. Coli* 0157 in Delaware continues to be a site-specific decision. Some hospital and private labs screen all specimens, some screen only diarrheas, some screen only on physician request. The Delaware Public Health Lab (DPHL) screens all stool cultures as CDC recommends, for these reasons:

- Patients infected with *E. coli* 0157 can be asymptomatic or can have nonbloody or bloody diarrhea. Only 1/3 of patients have >1 fecal leukocyte/hpf, therefore this is not a good screening tool.
- Many clinicians are not familiar with this pathogen, therefore may not request it.
- *E. coli* 0157:H7 is not identified by routine stool culture media, therefore an additional screening plate is required.

Because the organism does not ferment sorbitol, screening for this infection is relatively simple, using a MacConkey-Sorbitol plate. Clear, sorbitol negative colonies can be visualized, then screened for 0157 antigen using commercially available antisera. Colonies that test serologically positive should be confirmed with a biochemical identification and with H7 antisera. Serotypes other than H7 have not been known to produce toxin, however some non-motile strains may have lost their flagellar antigens, therefore may test negative. These isolates can be referred to CDC for testing for Shiga-like toxins (SLT).

If DPHL can assist you in your efforts to screen, identify, confirm or report *E. coli* 0157, please call us at 302-653-2870.■

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Academic Health Centers

E. Wayne Martz MD

I recently read a short report from the Lister Hill Center for Health Policy, a very erudite and academic organization, asking whether Academic Health Centers (AHCs) can survive in the evolving health care climate. I was more than a little surprised by their approach and conclusions. Some of the dogma that has guided medical education for over 50 years seems about to be tossed out the window.

We all realize that with the rapid and dramatic shift toward managed care, with emphasis on costs and controls, most AHCs face huge problems. They simply cannot compete on a cost basis with smaller, flexible community hospitals. They seem fated to be delisted. Not only do they have large residency programs to be supported (costs \$70,000 plus per resident) with full time salaried department heads and staffs, program directors and research, but also they practice a very expensive brand of medicine. To teach and demonstrate to the medical students and residents, they tend to document everything with laboratory reports and a wide variety of imaging modalities and procedures. Typically they send their third and fourth year students out to affiliated hospitals which cover their own costs, thereby saving millions for the schools, but even consider the cries that the USA now has too many doctors, and medical schools should reduce class size. Thus, even this source of cost savings may dry up as those hospitals fight for their own survival. Finally, tuition income, previously only a modest proportion of the total cost, now may

start to shrink. Yes, the question is very relevant, can AHCs survive.

The Lister Hill report concludes that AHCs have three functions: research, teaching and patient care. This is "olde dogma," and was often likened to the three legged stool that cannot stand on two legs. "You can't teach if you don't do research, and any research ultimately has to be related back to patient care," or so it was said. Now they propose two models of AHCs, each with a different role, goal and organization. One is the "Academic Services Model," and the other they call "Revised Traditional Model." The former would provide high volume standardized clinical services at competitive prices, and a very structured educational curriculum for all students emphasizing primary care. If there is any research at all it would be in the nature of "operations research" focused on ways to improve efficiency, quality and patient satisfaction.

The Revised Traditional Model would focus on tertiary care, biomedical research and the education and training of MD/PhD candidates and subspecialists. Patient volume would be low and highly selective in nature, representing the diseases and conditions under investigation. Members of the staff could participate in undergraduate medical student teaching, but not on site. The model would require flexibility, large amounts of data processing and would have to be structured for maximal communication. Performance would be measured by output, both in publications and finished candidates. Performance in the

Academic Model would be measured in patient outcomes, efficiency (cost control) and satisfaction. It would be more regimented and might suit entrepreneurs, but not artistes, researchers and creative thinkers who do better in an unstructured environment.

So the old dogma that you have to do research to teach is about to disappear. "Publish or perish" will no longer be the watchword except in the most advanced subspecialty arenas. What if this revolutionary concept spreads into undergraduate education as well? It boggles the mind! My guess is that the academics will not buy into it.■

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OBITUARIES

A Moment of Silence

In August 1995, in an effort to at least record and recognize the deaths of a number of our members, we published a list of those who had died 1992-94. Since then we have lost many more of the leaders of our medical community. The following is an effort to provide a little more information on those who were reported previously, and to update the reporting through 1995 and the first part of 1996.

We would still prefer to publish individual, personalized obituaries on everyone, and shall do so whenever these are received, as written by friends or family. Often those close to the deceased are too overcome to write, and after a few months are only trying to put it out of their minds. Thus days and weeks become months and years, to the point where it becomes embarrassing if we have not published something. In the future I shall try to recognize these every few months as we go along, and publish the more detailed ones whenever they are available.

I apologize for any factual errors in these writeups. Sources of reliable information are not always available. Corrections will be published as received.

E. Wayne Martz MD

Daniel A. Alvarez Born September 18, 1924, Havana, Cuba. Died May 1994 at the age of 69. Undergraduate education Camaguey, Cuba, graduating 1944. Thereafter pursued studies as an exchange student at Cornell University in public health, preventive medicine, and tropical medicine. Returning to Cuba he received the MD from Havana University in 1950. Because of unsettled conditions in Cuba his studies were discontinued and pursued in New York, Camaguey, Mexico City and elsewhere ending in Seaford around 1970. There he built up a successful practice of family medicine which he continued until his death. As a most likeable, energetic and interested man he became involved in a host of medical activities, became president of the Medical Society of Delaware in 1985 and thereafter Delaware's delegate to the AMA which he continued until his death.

It is recognized that this does not do justice to a man of the stature of Dan. It would take someone close to him who knew him well

to write such a piece, and three such have agreed to do so. When one is received it will be published. Meanwhile, this is better than ignoring the passing of this splendid man.

Alfred E. Bacon Jr. Full obituary published previously in the *Delaware Medical Journal*.

Joseph R. Beck Born 1907. Died November 1992. Graduate of Conn. Wesleyan (1929) Middletown, and University of Pennsylvania College of Medicine 1933 (MD). Post-doctoral training at Methodist Hospital, Philadelphia. Entered practice in Wilmington in urology. Board certified in 1954. Retired in 1989.

John C. Bradford Sr. Born in 1903. Died in December 1994 at the age of 91. He was raised in Pittsburgh and Wilmington, and was an accomplished athlete at Friends School. Graduated from University of Virginia and received his DO degree from Philadelphia Col-

lege of Osteopathic Medicine in 1928. He practiced medicine, specializing in otorhinolaryngology for 54 years, retiring in 1984. He was a leader in the Delaware osteopathic community, and was one of a small group of physicians who founded Riverside Hospital in 1954. The Intensive Care Unit at Riverside is named in his honor. He and his wife raised Irish setters for many years on Marsh Road. His wife predeceased him in 1990. He is survived by a son, Dr. Robert Bradford Jr, of Hockessin, two daughters, eight grandchildren and two great grandchildren.

Robert S. Brennan Born 1925. Died April 1995 at the age of 70. Was a graduate of St. Joseph University and Jefferson Medical College 1949. Residency in pediatrics at St. Christopher's Hospital for Children, Philadelphia. Served as a medical officer in the Army during the Korean conflict. Practiced pediatrics for 42 years. Was one of the original pediatricians to join in forming the St. Francis (Hospital) Pediatric Center 1987. Survived by his wife of 43 years, three sons, a daughter and eight grandchildren.

Thomas J. Bulger Born April 22, 1909. Died February 1994, at the age of 84. He earned his bachelor's degree from the University of Syracuse in 1932, and his MD from Columbia University Coll of P&S in 1936. He was a competitor in the 1932 Olympics in discus, shotput, and javelin, and during his military service 1942-46 was director of surgery serving the Manhattan Project (atomic bomb development) in Richland, Washington. He had been previously licensed in Delaware (1938) and returned here after the war for a total of 40 years of private practice. He was a surgical consultant for the DuPont Company for 33 years, and was chief of staff at the Wilmington General Hospital in the 1960s. His wife pre-deceased him (1977) but he was survived by three children and six grandchildren.

S. Ward Casscells Born 1915 in New York City. Died February 13, 1996 at age 80. Father died when he was five and mother

when he was 17, leaving him two younger siblings to parent. Educated at University of Virginia (MD) in 1939. Internship and residency at St. Luke's Hospital in Cleveland and A.I. DuPont Institute, plus extensive training and experience in the Army during World War II in North Africa, Italy and France. He practiced in Wilmington from 1949-86, at first with Dr. Shands but later by himself. He was Chief of Orthopedics at Wilmington General and Memorial Hospitals prior to merger. He was Clinical Professor of Orthopedics at Jefferson and was honored by his alma mater, University of Virginia, by having a Professorship named in his honor. He was honored by President Bush for his development of arthroscopy, principally of the knee. Started programs in arthroscopy at Jefferson Hospital, Yale, Massachusetts General and Brigham/Womans Hospital in Boston. Published books on arthroscopy in 1977 and 1984, and was known world-wide for his work in the field. He is survived by his wife of 47 years, two sons, two daughters and seven grandchildren.

Italo Charamella Born 1915. Died August 1994 at the age of 79. Was awarded the Bachelor's degree and MD from the University of Virginia, Charlottesville 1940. Served in the Army with distinction during WWII. Practiced general and family medicine in Wilmington until 1980, and thereafter worked for the Student Health Service at University of Delaware until retirement in 1985. Was police surgeon for the City of Wilmington 1949-60. Survived by his wife, a son, a daughter and six grandchildren.

Sidney Chavin Born April 25, 1899 in Russia. Came to USA at age 15, and after two years of study qualified to enter the University of Delaware. From there he entered Temple Medical School, from which he graduated with honors, a member of the second graduating class. He was licensed to practice medicine in Delaware the following year (1926) and practiced general medicine here for over 60 years (1986). He was known for his love of opera, and for over 35 years attended the Metropolitan Opera in New York

City. He was a religious man, a member of Beth Shalom Congregation. The focus of his medical practice was on St. Francis Hospital. He died in August 1993 aged 94.

Allan R. Cruchley Born 1903, Panama. Died February 1996 at the age of 93. Educated at Georgetown University, both undergraduate and medical. He practiced general medicine with a special interest in obstetrics in Middletown for 53 years. During that time he traveled to Wilmington General and St. Francis hospitals in Wilmington and Union Hospital in Elkton, MD to care for his patients. He was active in Middletown area politics in the 1940s and 50s, serving on Town Council and later on the School Board. His wife of 52 years died in 1986. He is survived by a son, two daughters, nine grandchildren and seven great grandchildren.

H. George DeCherney Born in 1920. Died in July 1993. A full obituary was published. Graduate of Villanova University and Temple Medical School (1944), practiced psychiatry in Delaware from 1949 to 1993. Was chairman of the department of psychiatry from 1963-72. Received many awards. Known for his love of art and Italian culture.

John J. Egan Born Sept 4, 1924, Trenton, NJ. Died Feb 1996 at 71 years of age. Educated at Williams College (BA 1945), then service as an Ensign 1946-47. He returned to study medicine at Yale (MD 1951). Internship and residency in internal medicine at St. Luke's Hospital, Chicago 1951-54 followed by Fellowship in hematology at Ohio State 1954-56. He came to Wilmington as the first trained hematologist in the state in 1956 and was a powerful influence on the course of medicine in Delaware and the region from then until his death. He was a quiet but firm and positive man of tremendous intellectual capacity but so modest and unassuming that it was sometimes overlooked. He put together an outstanding group of hematologists by his unerring judgement of character and competence. He developed and guided the Blood Bank of Delaware to a position of national prominence by virtue of having a majority of

the people of the state enrolled. His absolute integrity, straightforward manner and caring personality inspired confidence in patients and colleagues alike. He published a number of seminal articles, chiefly on the development of the automated white cell counter, but also on giant platelets and clotting factors. He pioneered in the development of a bone marrow transplant service in Wilmington. The tragic death of his wife in an automobile accident with him in 1993 seemed to affect him deeply. He is survived by two sons, two daughters and seven grandchildren.

Helmi El Ramli was an Affiliate member of the Medical Society of Delaware with his permanent home residence listed as Honolulu, Hawaii. He received his MD degree from Abbasis Faculty of Medicine of Ain Shams University, Cairo, Egypt in 1953. As far as is known his work in Delaware was confined to the Emergency Department of the Medical Center of Delaware. We have been informed that he died February 7, 1994. No further information available.

Laurence Fitchett Died in June 1995. Received his MD from University of Wisconsin in 1931. No other information available.

Mildred B. Forman Born in 1904 and died in September 1993 after a short illness. She was a Wilmington native, a direct descendant of Tyman Stidden, the first Delaware physician and surgeon, who arrived from Sweden on the Kalmar Nyckel. She was a graduate of Friends School (Wilmington), University of Delaware and the Medical College of Virginia (Richmond). She was one of three women in her medical school class of 94 students, and when she entered medical practice in Delaware was one of four women practicing in New Castle County. She was a member of the medical staffs of all Wilmington hospitals (except Riverside).

James Vincent Gallagher Born in October 1932 and died in March 1993. Graduate of Mount St. Mary's College and University of Virginia, Charlottesville 1958. He was initially licensed to practice medicine in Vir-

ginia, but in 1964 entered residency in orthopedics in the Washington Hospital Center (D.C.). Part of his training brought him to Alfred I. DuPont Institute in Wilmington. When he completed the residency in 1969 he worked briefly in the V.A. Hospital in Elsmere, but in 1970 opened his office as the first orthopedist in Dover. He practiced there, widely respected and admired until his untimely death.

Phyllis DeVito Gallaher Birth year not available. Died March 1995 of arteriosclerotic cardiovascular disease. Received her MD in 1928 from Womens' Medical College of Philadelphia and took residency in Obstetrics and Gynecology at the Margaret Hague Hospital in Jersey City, New Jersey which at that time was considered the finest available. She practiced in Hartford, CN and New York City from 1932 to 1952 when she came to Wilmington with her husband who also is a specialist in Obstetrics and Gynecology. She was on the staff of St. Francis Hospital and the Medical Center of Delaware. She retired in 1982. She is survived by her husband, William Thomas Gallaher.

Elmer R. Gross Born in 1908, died in April 1995. Received his MD from University of Michigan in Ann Arbor in 1933. Entered practice in Wilmington the following year (after internship) as was the custom at that time, but later traveled to Columbia University, College of P&S for training in dermatology. He was Board certified in dermatology in 1942 and was the pioneer dermatologist in Wilmington until he retired in 1987. He moved to Jerusalem, Israel and lived there until his death. He traveled frequently back to his home on Rockland Road, Wilmington. Survived by his wife, two sons, one daughter and eight grandchildren. One daughter predeceased him, and his first wife died in 1961. A complete obituary was published in *DMJ* February 1996.

Gerhard E. Hartenauer Born October 30, 1921, in Germany and died October 1994 at the age of 72. Received the MD degree from

the faculty of George August University in Gottingen 1952. Interned at Atlantic City Hospital 1953-54. Residency in medicine at Delaware Hospital, Wilmington 1956-59. Practiced internal medicine in Wilmington thereafter until retirement in 1986. Survived by five daughters and eight grandchildren.

William R. Hazzard Born April 14, 1911, Claymont, Delaware. Died January 1993, aged 82. Graduated Wilmington High School, Temple University, Hahnemann (MD) in 1936. Received Delaware license in 1937, and post-doctoral from University of Pennsylvania in otorhinolaryngology. Certified in 1942. Practice centered around Memorial Hospital from 1938 until about 1975. Was clinical chief of ENT. Retired to his farm near Unionville, PA to ride and fox hunt. Loved football and played semi-pro in his youth. Army service in WWII at Valley Forge. Survived by one daughter, one son and two grandchildren.

Lemuel Herrera Born October 18, 1949, and died in 1995 abruptly of a coronary. From a prominent Mexican family, he was educated in Mexico and received his MD from Autonomous University of Guadalajara in 1972. Residency in Surgery from 1975-80, followed by a fellowship in Oncologic Surgery from 1980-82 at Roswell Park, Buffalo. He was Board certified in 1984. Went on to a distinguished and meteoric academic, research and surgical career in oncologic surgery. Returned to Delaware briefly. We received word of his abrupt and untimely death at 46.

Leo B. Hogan Born March 1, 1937 in Lewiston, Idaho. Died August 1993, aged 56. Graduated from Princeton University in 1959, University of Utah College of Medicine (MD) in 1964. Was an intern and resident at Delaware Hospital, Wilmington 1964-68. Private practice of internal medicine 1968-92 in Wilmington. He was a graduate of Alexis I. DuPont High School in Wilmington and served as their football team physician for 20 years. Was a strong fan of Flyers hockey.

David S. Howard Born 1924. Died 1993

after an illness of many years. Was chief of pediatrics at Beebe Hospital for 22 years. Member of DIMER Board 1979 through 1985 and served as its president. A previous full obituary was published.

W. Garrett Hume Born December 3, 1913. Died July 1994. Received his MD from Temple University in 1941, interned at Delaware Hospital 1941-42. Army Combat Flight Surgeon 1942-46 and saw action in North Africa and the European Theater. He practiced in Selbyville, DE 1946-50 and thereafter did occupational medicine for the DuPont Company. He was on the staff of Beebe Hospital and Peninsula General 1946-50, Salem County Hospital (NJ) 1952-66. Was president of Salem County Medical Society 1957-58. He was a member of the American Academy of Industrial Medicine. After he left the DuPont Company's Chambers Works site about 1966, he retired to Northampton County, Virginia where he lived until his death. He maintained an Affiliate membership in the Medical Society of Delaware. Little is known of his family life, but his widow is still living. His father was at one time administrator of the Delaware Hospital.

Edgar N. Johnson Born 1915, Everett, Massachusetts, raised in New Hampshire. Died in March 1993, at the age of 78. Graduate of University of New Hampshire in 1937, Jefferson 1942. Interned at Delaware Hospital, Wilmington where he was inspired to go into ENT. Served in the Navy WWII then residency in ENT at Columbia-Presbyterian in New York for three years. Practiced in Wilmington until 1958 when he went to Mt. Sinai Hospital in New York and to Vienna for further study and training in otology, to which he confined his practice thereafter. His very devoted patients named him Man of the Ear at a major social function in Wilmington 1967. Survived by his wife, five sons, eight grandchildren.

Leonard P. Lang Born 1913 in Philadelphia. Died in November 1995. Graduate of Penn State University 1935 and Jefferson

Medical College 1939. Internship and residency in pathology and medicine at Mt. Sinai Hospital, Philadelphia, now part of Albert Einstein Medical Center. Practiced internal medicine with emphasis on pulmonary disease, in Wilmington from 1952 until his death, a most distinguished career with many honors and awards. Much beloved by hundreds of young physicians whom he taught and trained at the Medical Center of Delaware as chairman of the Department of Medicine and later as Emeritus. Was Professor of Medicine at Jefferson from 1970. Survived by wife Wilma, one son, two daughters, five grandchildren and two great grandchildren. A previous remembrance was published in *DMJ* April 1996.

Samuel W. Lippincott Born 1918 in Baltimore, Maryland. Died January 1993 at the age of 75. Graduate of Medical College of Virginia, Richmond (MD) in 1944. Interned at Union Hospital, Baltimore. Residency in radiology in Columbia, South Carolina and Lahey Clinic, Boston. Certified in radiology 1951, became director of radiology at St. Francis Hospital, Wilmington from 1961 to 1987.

James C. Lyons Jr. Licensed in Delaware in 1947 and practiced here until 1984 when he moved to Virginia. Dr. Lyons conducted a general and family practice together with industrial medicine. His principal hospital base was at the Memorial which later became part of the Medical Center of Delaware. We recently received word of his death, date and circumstances not known.

Douglas W. MacKelcan Born 1920. Died December 1994 at the age of 74. He was graduated from Connecticut Wesleyan University in 1942, and from Jefferson Medical College with the MD in 1945. Residency training and military service delayed his entry into practice until 1949, but he practiced family Medicine thereafter in Wilmington until his retirement in 1989. He was very active in professional (AAFP, Del. Curative Workshop) and community affairs (Rotary, Appalachian Mountain Club) as well as an active personal

life (Wilmington Country Club, golfing, hiking, sailing, skiing). He was medical director of four retirement communities and was active in residency teaching at the Medical Center of Delaware and St. Francis Hospital. He is survived by his wife, three sons, two daughters and seven grandchildren.

John W. Maroney In the process of being written.

James E. Marvil Born in 1904, in Laurel, Delaware. Died in January 1996 at the age of 91. Educated at University of Delaware and Jefferson Medical College (MD). Army WWII 30th Field Hospital, Commander of 32nd Evacuation Hospital. Did family practice in Laurel for six years, then trained in ENT in Vienna which he practiced until he retired in 1980. Interested in the sea as it related to Sussex County and the Delaware coast and Delaware history. Wrote two books on the subject, one on boats, the other on watermen. His home on the canal was filled with historic memorabilia. Was a co-founder of the Lewes Historical Society in 1962. Full obituary was published in *DMJ* of May 1996.

James R. McCarthy Born 1924. Died March 1994 at the age of 70. He was born and raised in Wilmington, and graduated P.S. DuPont High School. He was a track star at University of Delaware, graduated Yale University and MD from Hahnemann in 1948. Interned at Memorial Hospital, Wilmington. He saw military service in the Army, WWII and Korea. He was a member of the American Academy of Family Practice and practiced family medicine in Wilmington for 40 years. He is survived by his wife, a son, two daughters and four grandchildren.

Donald H. McGee Born 1924 and died May 30, 1996 at age 72. Educated at Dickinson and Jefferson (MD) in 1947. Certified in pediatrics in 1955. Came to Delaware in 1947 as an intern at Delaware Hospital. Practice in 1950, Chair of St. Francis Pediatrics from 1950-80 (alternating). Co-founder of St. Francis Pediatric Center in 1987. Army World War II and Korea. Competitive bridge

player - life master. Survived by wife of 49 years, a son, two daughters and four grandchildren.

Eugene R. McNinch Born 1912. Died May 1993 at age 81. Graduate of Washington/Jefferson University and University of Maryland College of Medicine with MD. Residency at Radiology University Hospital, Baltimore. WWII Army, served in the 4th Infantry Division at the invasion of Normandy. Practiced briefly in Weirton, WV and Towson MD before coming to Dover 1952 as chief of radiology, which position he held until 1977. Was on Delaware Board of Health 1957-66, president in 1960. Involved in numerous community and national organizations including Sons of the American Revolution. Survived by son, daughter and 10 grandchildren.

Peter J. Mette Born 1927 Hamburg, Germany. Died March 1996 at the age of 69. Received his MD degree from the University of Hamburg, 1953, immigrated to the USA and took residency in surgery at Lewis-Gale Hospital, Roanoke, VA. He switched to residency in anesthesiology at the University of Virginia which he completed in 1961. He moved to Wilmington the same year as a staff anesthesiologist at the Delaware Hospital where he worked until 1986. He then worked for Zeneca Pharmaceuticals. He is survived by his wife of 42 years, three sons and one daughter. He was a mainstay of the Education Committee of the MSD in obtaining accreditation for the Society.

Gottfried Metzler Jr. Born 1904 in Philadelphia. Died May 1993, at age 89. He received the MD degree from Jefferson Medical College. Initially started practice in Ocean City, NJ but moved to Bridgeville, Delaware where he practiced family medicine 1928-1978. Retired to Ocean City, New Jersey. Survived by wife, son, daughter, five grandchildren and two great-grandchildren.

Peter J. Olivere Sr. Born 1914. Died April 1995 at age 81. Raised in Wilmington, graduate of Salesianum High School in 1930. Georgetown University (1934) and

Georgetown University Medical School (1937). He had a distinguished Army career in North Africa, Italy and France. (See *DMJ* Dec 1994). He trained in radiology at University of Pennsylvania and was a radiologist at St. Francis Hospital, Wilmington 1946-1969 when he retired as Chief. Thereafter he was in private radiology practice and at Delaware State Hospital until 1985. He is survived by his wife, a son, two daughters and seven grandchildren.

Lyman J. Olsen Born January 11, 1927 in Utah. Died November 1995 at age 68. Educated both undergraduate and medical at University of Utah, receiving the MD 1954. He was trained in pediatrics and certified in 1959, but in a few years resumed his education, receiving the MPH from the University of California, Berkeley. He went to work at Utah's Public Health Division, rising rapidly to director. In 1979 he resigned and went to Egypt directing a technical advisory team for the Egyptian government developing an extensive urban health project. In 1982 he came to Delaware as Director of the Division of Public Health. A mild and gentle man with deep convictions, in 1989 he moved into a more controversial position in Community Health where he worked until his death of congestive heart failure. His wife predeceased him in 1986. He is survived by one son, three daughters and six grandchildren.

Girard S. Serino Born 1907. Died October 1994 at the age of 87. A graduate of Bucknell University, he received the MD from Jefferson Medical College following which he spent a year in Vienna and another year in post-doctoral work at the University of Pennsylvania. He was Chief of Surgery at St. Francis, Wilmington from the 1940s to the 1960s. He retired at age 65 and thereafter worked as a consultant at the Veterans Administration. He was a member of the International College of Surgeons. Survived by his wife and two sisters.

Richard W. Skinner Born 1926. Died January 1995, abruptly of a coronary thrombosis at the age of 69. A graduate of Dickinson College and Jefferson Medical Col-

lege (MD) in 1948. Residency in anesthesiology at Delaware Hospital 1948-50. From 1952-72 he was chief of anesthesiology at Altoona Hospital (PA), and from 1972-86 he was a staff anesthesiologist at the Delaware Division of the Wilmington Medical Center. Thereafter he volunteered his time at the MCD-AIDS Clinic. He is survived by his wife of 48 years, three sons, a daughter and six grandchildren.

Oleh O. Sluzar Born August 4, 1922. Died June 1994 following surgery, at age 71. Was born and raised in the Ukraine, educated at University of Lviv, Ukraine. Received MD from Phillips University, Marburg, Germany 1949 and came to the USA in the same year. Interned at Mercy Hospital, Buffalo and residency in medicine at Memorial Hospital, Wilmington, DE. Worked at Emily Bissell Hospital, Wilmington 1953-56, then opened his office for private practice on Augustine Cut-off which he maintained until the time of his death. He was associated with the Veterans Administration as a consultant 1959-89. He was very proud of his Ukrainian heritage and headed the Delaware Chapter of the Ukrainian Congress of America for many years. He had wide ranging interests in Eastern European history, flower gardens, music, piano and bridge. He is survived by three sisters.

Harold P. Sortman Little information was available. He was graduated from Jefferson Medical College in 1936 and did general practice in Wilmington for many years. He was active until the time of his death in December 1994.

Robert F. Spicer Born in 1930, and died on March 2, 1996 at age 66. Graduated from Georgetown University Medical School. Residency in Orthopedics at Johns Hopkins Hospital, Baltimore. U.S. Air Force, retired. Practiced in Bethesda from 1963-84 when he moved to Lewes and practiced there from 1984-94. Survived by wife, a son, two daughters and six grandchildren.

Sidney Stat Born 1904. Died October 1993 at age 89. He was a graduate of Wilmington High School and the University of Pennsylvania, received the MD degree from the University of Pennsylvania, 1928. Interned at the Jewish Hospital, St. Louis, Missouri. Thereafter worked for three years as house physician at St. Francis Hospital, Wilmington, Delaware, then practiced family medicine for over 60 years in Wilmington. During WWII he served in the Army in the 83rd Infantry Division and was awarded the Silver Star. During his years in practice he was known for not keeping patient records, retaining everything in his mind. Reports he received were given to the patients. For a number of years he worked as Coroner's Physician, later Deputy Medical Examiner in addition to his practice.

Jane C. Straughn Born 1932 Buffalo, New York. Died November 1993 at age 61. Graduated from University of Delaware in 1953 and received the MD from Johns Hopkins University School of Medicine in 1957. Interned at Bellevue Hospital, NYC and took residency in medicine and fellowship in gastroenterology at Hahnemann Hospital, Philadelphia. She

practiced gastroenterology in Wilmington from 1962 to 1992 on the staffs of Medical Center of Delaware and St. Francis Hospital. Was president of New Castle County Medical Society 1983-84. Fellow American College of Physicians in 1990.

Jack R. Zahn Born in 1913 and died in January 1996 at age 83. Went to school at Lafayette, graduating in 1933 and received his MD at Yale in 1938. He was raised in Ohio and New Jersey. Joined DuPont in 1941. Was Assistant Medical Director in 1966 and Director in 1972. Board certified in 1955 for Occupational and Preventive Medicine. Oversaw DuPont Co medical facilities world-wide from 1972-77. Survived by wife of 54 years, two sons, one daughter and seven grandchildren.

No information was available on the following physicians:

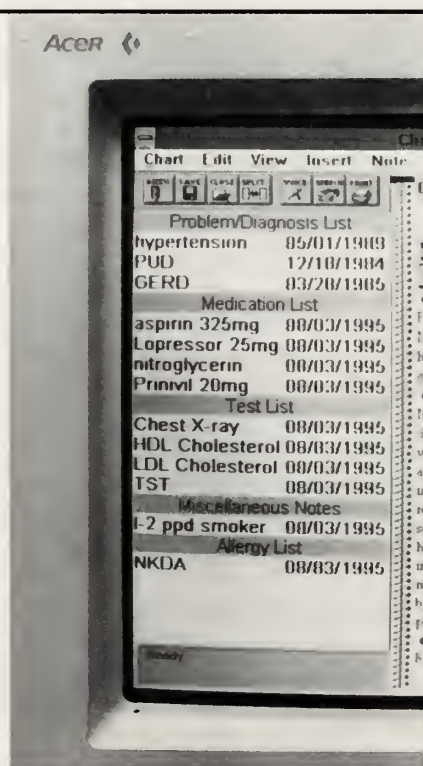
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LETTERS TO THE EDITOR

HMOs: A Solution

In the June issue of *Delaware Medical Journal*, James F. Lally MD's, "An Implied Social Contract," clearly illustrates the great problems with our now preponderant for-profit HMOs. They amass huge sums of money for their stockholders and executives, but cover little of the societal burden of indigent care, medical training, and medical research.

These problems will not be solved until most HMOs are not-for-profit. In our democratic society this will not, and should not, occur by government fiat. The first step should be for state insurance commissions to require the for-profit HMOs to shoulder their share of the societal cost of indigent care, etc. The remainder should be a matter of education, of physicians, of hospital administrators, of employers, and of the general public re: the advantages to our society of eliminating stockholders' interests being imposed between patients and their health care. Medical societies should and must take the lead in this educational process. It will not be easy.

David Platt MD

Update: World War II — Certificate of Service Papers

In the Special Article, "Reflections on World War II: Part II," *Del Med Jrl*, December 1994, Vol 66, No 12, I provided on page 688 the address to which Army veterans or their next of kin could write to obtain their Certificate of Service (Discharge Papers). In a recent publication by the Department of the Army it was stated that, "ARPERCEN destroys pre-'95 requests."

The purpose of this action was, "... to improve response time to written inquiries from retirees (and others) ... In most cases, written requests submitted before 1995 are being removed from a pending status and destroyed."

Those who submitted a request before January 1, 1995, and never received an answer are asked to resubmit the request to the National Archives and Records Administration (NARA). The acting director of the Veterans Services Directorate (VSD) said, "It may sound like a harsh solution to our backlog problem, but in the long run, it will improve customer service, and that is our ultimate goal."

AMPERCEN will still handle inquiries for decorations and awards, service verification and the issuing of identification cards.

Remember, all requesters must provide as much identification as possible, i.e., name, rank, social security number/military service number, date of birth, dates and places of service. If you are a "next of kin" you must also provide a marriage or birth certificate to prove your eligibility to receive this information.

The address for now submitting such inquiries is:

National Personnel Records Center
Attn: Army Reference Branch (NCPMA)
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William H. Duncan MD

Giving Credit Where Credit Is Due

I would like to share with you a funny incident that occurred recently in my office. Please consider this for publication:

A gentleman patient who has been under my care for many years was recently in for an office visit. Upon leaving, my receptionist stated the fee for the office service, and noticed that he had a credit on his account. When she brought this to his attention so she could deduct the amount from the current fee, he told her that his overpayments were deliberate. He stated that he could not understand why his doctor charged considerably less than he charged his clients — and he was a plumber. To him, this made no sense. My receptionist, who found herself in a rare moment of speechlessness, could not argue his logic. He then handed her another check, which contained yet another overpayment.

Anonymous

An Addendum to an Obituary

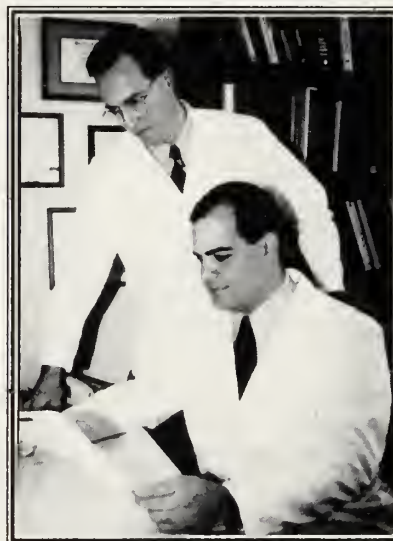
Dr. William Shellenberger did a great job in his synopsis of the busy medical life of our sorely missed colleague and friend, Al Bacon, whom I first met when he was a medical resident while I was also in training in internal medicine at the then Delaware Hospital.

It is true that Al and I were the first Delaware Hospital Home Care physicians, but we were shortly if not immediately joined by Dr. Carl Glassman. I think Dr. Bud Riegel was also a participant in the program. Somewhere there is a written history of the Home Care Program, another of the innovations of Dr. Lewis Flinn, but I do not know where or if it is still to be found.

Bernadine Z. Paulshock MD

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June 1996**

Leadership Activities

- Martin G. Begley MD and Donald R. Doran DO represented the Society at hearings convened by the Delaware Health Care Commission regarding managed care.
- Virginia Collier MD, Mark Meister, Beverly Dieffenbach and Heidi Sigmund represented the Society's continuing medical education program at a reaccrediting inspection in Chicago.
- Mr. Meister met with Secretary Nazario to discuss the Society's efforts to promote the regulation of managed care.
- Charles L. Reese IV MD and Mr. Meister represented the Society at an organizational meeting of the Delaware Health Information Network.
- Leslie W. Whitney MD, W. Thomas Short and Mr. Meister met with the dean of the University of Delaware Center for Urban Affairs regarding a statewide video/telemedicine network.
- A delegation from the Medical Society attended the annual House of Delegates meeting of the American Medical Association. In attendance were: Stephen R. Permut MD, Delegation Chairman; Robert G. Altschuler MD and James P. Marvel Jr MD, Delegates; Michael J. Bradley DO, I. Favel Chavin MD and Raphael A. Zaragoza MD, Alternate Delegates; Carol A. Tavani MD, OMSS Delegate and Timothy Wong MD, Resident Representa-

tive along with Mr. Meister, MSD Executive Director.

Physicians' Advocate Program Activities

- Presented "OSHA Rules and Regulations for the Medical Office," which was led by an OSHA field representative and provided pertinent information to offices required to meet 1996 OSHA regulations.
- The first contract review (MAMSI-Physicians Health Plan of Maryland, Inc.) in the 1996 *Managed Care Contracting Service* was sent out.
- *Physicians' Advocate* was the guest speaker at Kent General's luncheon workshop "How to Run a More Profitable Practice."
- Provided the following consultation services: 1)consulting to two practices dealing with practice management, 2)consulting on establishing a new practice to two physicians, 3)taught an in-service on Front Desk Procedures to one office.
- Attended the Xact Transition Consulting Team meeting
- Mr. Meister and Ms. Siwek met with Phil Pennington, Vice President XACT Medicare External Relations, regarding concerns over lab practices.

Credentials Verification Organization (CVO)

- The Credentialing Verification Organization was renamed the *Credentialing Connection - Delaware's Professional Verification Service*.

- Completed prototype of Credentialing Connection application for physician completion.

Continuing Medical Education Activities

- Sponsored 16 educational activities for Category 1 credit.

Other Activities

- The following physicians served as "Doctor of the Day" at Legislative Hall in the month of June: Louis E. Bartoshesky MD MPH, Martin G. Begley MD, Michael J. Bradley DO, William H. Duncan MD, John A. Forrest Jr. MD, Robert W. Frelick MD, Neil S. Kaye MD, Vincent Lobo DO, Jorge A. Pereira-Ogan MD, Stephen R. Permut MD, Richard A. Sherman MD.



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IN BRIEF

Leptin Receptor in Obese Humans Is Normal

In findings published in *Diabetes*, researchers have determined that obese individuals have the same amount of leptin receptor as lean people and that the structure of the receptor is the same in lean and obese persons. The leptin receptor is the specialized site in the brain that receives the message carried by leptin, the obesity hormone. This research suggests that the receptor is not the problem in obese persons who have high levels of leptin and still gain weight.

Leptin is the recently discovered hormone whose job is to inform the brain about the amount of fat in the body. These researchers have recently demonstrated that leptin is elevated in the blood of obese humans. Since obese humans have high levels of the leptin hormone, yet continue to gain weight, it appears that these people are resistant to the actions of leptin. The defect that results in leptin resistance is yet to be determined.

The article is the latest research to define leptin resistance in humans. Researchers have previously ruled out defects in the fat cells or circulating levels of leptin in the blood. Recent studies on the leptin receptor in animals have found genetic defects that should impair its normal function.

Save the Date

The American Osteopathic Association will hold its annual business meeting, July 16-21, 1996, at the Opryland Hotel in Nashville, TN. For more information, please contact Michelle Toscas (312) 280-5882 or (800) 621-1773, ext.5882.

The AOA's 101st Annual Convention and Scientific Seminar will be held from October 7-11, 1996, in Las Vegas, NV. More than 7,000 DOs and others related to the profession are scheduled to attend the meeting, which will feature educational sessions and exhibits. Call the AOA's Michelle Toscas for more information.

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INFORMATION FOR ADVERTISERS

The *Delaware Medical Journal* is a monthly publication of the Medical Society of Delaware. The *Journal* reaches approximately 75 percent of the state's physicians, as well as medical libraries, and hospitals; its circulation is approximately 1,640.

Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting.

Closing for space reservations is the first of the month, two months prior to publication. Closing for materials is the first of the month, one month prior to publication.

All advertisements are subject to approval by the Publications Committee of the Medical Society of Delaware.

For a media kit or for more information, call Heidi Sigmund, assistant editor, at 302/658-7596 or 800/348-6800 (Kent or Sussex Counties).

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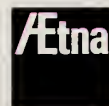
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Scientific articles on medical matters are especially welcomed, including case reports, clinical experiences, observations and information on matters relevant to medical practice. Other material may also be accepted if the editorial staff deems it of interest to *DMJ* readers. All submissions should include a brief summary.

It is highly recommended that authors familiarize themselves with *DMJ* style before submitting manuscripts for consideration.

All material for publication should be submitted either on a 3 1/2" computer diskette in WordPerfect 6.0, or typed or printed out on good-quality paper (one side only, double-spaced, one-inch margins). The ideal manuscript length is two to 12 pages. Up to 12 references per manuscript will be accepted, each keyed with superscripts in the text in the order cited. The format should follow that used in the *Index Medicus*. Authors are responsible for the accuracy of the citations.

Graphs, charts and black-and-white glossy photographs are accepted if important to the understanding of the text, but should not exceed four or five pieces. Each should have a label affixed on its back indicating its name, number, and "top." A separate legend should be provided for each. Do not write on the back, or scratch or mar them using paperclips. Do not mount them on cardboard.

Photos of patients should generally be taken in a way that obscures the patient's identity. Photos in which a patient's face must be clearly see, however, must be accompanied by signed release forms.

All manuscripts are reviewed by the editor and all scientific articles are then sent for peer review by members of the Editorial Board and/or other appropriate physicians. The usual processing time to publication is two to four months, though in some circumstance this may be longer or shorter.



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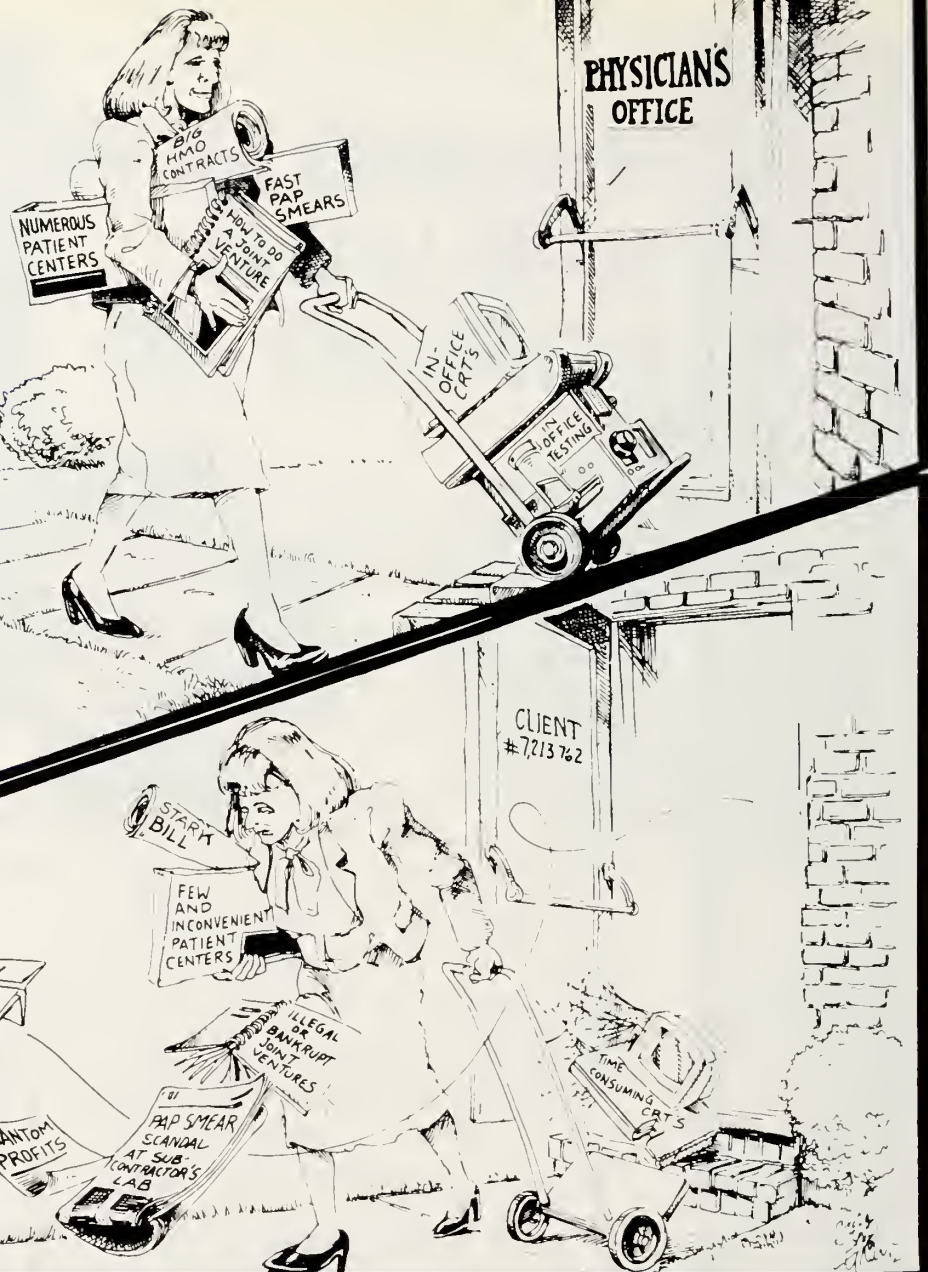
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Meeting the Challenge

The theme of my presidency, as many of you are more aware than perhaps you wished to be, has been that of physician unity and organization, based on the premise that only as a unified whole can we represent a successful, powerful force in negotiating the present environment of managed care and other challenges to the delivery of quality medical care and to the very survival of the practice of medicine.

Toward that end, at its July meeting, the Board of Trustees voted unanimously to implement the Managed Care Strategy Initiative report presented to it. In so doing, it has incepted very possibly the most far-reaching endeavor the Medical Society has thus far undertaken.

The report detailed the findings of an intensive, four-month study of the health care environment, with particular attention to managed care in Delaware. It concluded that Delaware physicians have a very real need for assistance by some organization which is not affiliated or otherwise complicated by loyalties or fiduciary responsibility to an insurance company, hospital board, group of investors or other stockholders, and it set forth specific recommendations along with a proposed action plan for their implementation.

Consequent to this landmark Board action, therefore, I am pleased and excited to announce to you the formation of a new subsidiary of the Medical Society; its name is Medical Network Management Services of Delaware, Inc; abbreviated as MED-NET of Delaware. This is a for-profit corporation,

wholly owned by the Medical Society. Its purposes are as follows:

1. to facilitate and enable physicians of Delaware to assume a leadership role in the delivery of quality medical care to the citizens of this state;
2. to facilitate the development and operation of timely and relevant medical care delivery models;
3. to foster strategic alliances and collaboration amongst those parties integral to the health care delivery system; and
4. to promote physician unity.

The corporation will contain two specific service divisions. A consulting division will assist local networks of physicians to develop and operate a physician organization (PO) for the purposes of education, contracting with managed care companies, managing risk, and managing utilization. These POs will be completely owned and controlled by physicians. Once a PO is operational, MED-NET will then assist that organization in obtaining its contracts.

The second division of MED-NET will provide a full range of administrative support services specifically designed to help ensure the success of the physician organizations; these services range from utilization management and performance improvement to data tracking and management for each organization.

The Society's vision is that this venture will provide Delaware physicians with the means they need to position themselves optimally to meet the challenges that lie ahead in

the quest to deliver the highest quality medical care in the face of an ever-changing environment. It represents an aggressive, proactive approach toward shaping and controlling our destiny. Deny its need and throw yourself at the mercy of those who would usurp that control and who have, to considerable degree, made inroads in that direction already.

For more information about MED-NET of Delaware, contact the Medical Society to schedule an educational meeting. ■



Carol A. Tavani MD

Gone are the days when caring for our patients was done only in an office or hospital. Today caring means working on a national level to preserve patients' rights. It means supporting your local, state and American Medical Associations. Only by working together can we achieve a new day in health care for all patients.

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1. _____ Tracking and informing physicians and spouses of health care legislation and legislators' voting record.
2. _____ November 16th Annual Meeting at the Hotel DuPont.
Speaker: Eleanor Craig PhD,
University of Delaware economist
Topic: *Health Legislation*

Speakers: Senator Roth's, Senator Biden's and Representative Castle's healthcare assistants
Debate: *Healthcare Legislation*
3. _____ Sharing Card for DMEF, AMA, ERF or community centers Delaware Medical Education Foundation.
4. _____ Winter luncheon with legislators in Dover.
5. _____ March 8, 1997 wine tasting, dessert, and dancing at Longwood Gardens.
6. _____ Spring luncheon and meetings with our congressmen in Washington.
7. _____ May annual meeting

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Effect of Primary Care Referral on Emergency Department Use: Evaluation of a Statewide Medicaid Program

James M. Gill MD, MPH
James J. Diamond PhD

Background and Objectives: Medicaid recipients without a regular source of care frequently use hospital emergency departments (EDs) for minor problems. This study examined whether referring Medicaid patients to primary care physicians and obstetricians results in a decrease in ED use and an increase in physician office visits. *Methods:* The statewide Voluntary Initiative Program (VIP), which referred Medicaid patients to primary care physicians and obstetricians without any managed care component, was examined. Claims data were reviewed for Medicaid clients 0-64 years old who obtained VIP referrals during the first five months of the program. The change in rate of visits to hospital EDs and physician offices was compared for the study group (n=444) and for the state's overall Medicaid population (n=40,860). *Results:* After referral, ED use decreased 24 percent for the VIP group and 4 percent for the Medicaid population. During the same period, physician office visits increased 50 percent for the VIP group but decreased 13 percent for the Medicaid population. *Conclusions:* Even in the absence of managed care, referral to primary care physicians and obstetricians resulted in fewer ED visits and more physician office visits. These findings confirm the importance of primary care in improving the efficiency of health care delivery for the Medicaid population. (Fam Med 1996;28:178-82)

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The use of hospital emergency departments (EDs) has increased dramatically over the past 10-15 years, due primarily to the use of EDs for nonurgent problems.^{1,2} Use of EDs for nonurgent problems may have negative consequences such as higher costs³⁻⁵ and overcrowding that can result in inadequate care for those who truly require emergency services.^{6,7} Nonurgent ED use is particularly high for the Medicaid population^{1,8,9} and has contributed to increased costs for state Medicaid programs.¹⁰

One reason for higher ED use among Medicaid clients could be that they have poor access to primary care and, therefore, have few alternatives to the ED for care.^{1,8} Based on this assumption, many states have attempted to reduce ED use by increasing Medicaid clients' access to primary care. One approach that has become increasingly common among Medicaid programs is managed care.¹⁰ Evidence shows that such programs may increase access to primary care.^{1,11,12} and decrease ED use.^{10,12-14} However, a number of problems exist with managed Medicaid programs, including the need for a federal waiver and lack of adequate physician networks to operate efficient managed care programs in some communities.¹⁰

One way to provide access to primary care without the problems inherent in managed care programs is to refer patients to a primary care physician who is willing to be a regular source of care. However, programs that have referred patients without any managed care component have not shown any decrease in ED use.¹⁵⁻¹⁷ No studies have examined such referral programs specifically for the Medicaid population.

In 1993, the Delaware Medicaid program embarked on an effort to increase access to primary care by referring patients to primary care physicians. The program, known as the Voluntary Initiative Program (VIP), is operated jointly by the Delaware Medical Society and the Delaware Department of Health and Social Services. The VIP is intended to refer Medicaid clients to a regular source of medical care. All state Medicaid clients are eligible for the program. Both clients and physicians participate on a voluntary basis. The referral process is initiated when the client calls the VIP referral number. The program has no managed care component, but primary care physicians are expected to remain the regular source of care for patients who are referred to them. In the first two years of the program, nearly 3,000 referrals were made to 200 physicians (50 percent to family physicians, 30 percent to general pediatricians and general internists and 16 percent to obstetricians). Delaware has approximately 70,000 Medicaid clients and 1,000 primary care physicians.

This study sought to determine if the VIP was successful in decreasing use of hospital EDs and in increasing use of office-based physicians during the first six months of operation. We hypothesized that people referred to the VIP would have a decrease in ED use and an increase in physician office visits, when compared to the rest of the state's Medicaid population.

Methods

This observational study examined use before and after referral for a study group (VIP participants) and a comparison group (non-VIP participants). The study group included all Medicaid clients aged 0-64 years who were continuously enrolled in Delaware's Medicaid program for one year and who had been referred to a physician through the VIP during the first five months of operation ($n=444$). The five-month period was chosen so that, for all patients, at least one month would have elapsed from referral to the end of the period of observation. To allow for short administrative breaks in enrollment, clients who were enrolled in Medicaid for at least 11 months of

the year were considered continuously enrolled. The comparison group included all state Medicaid recipients with the same age and enrollment criteria who did not participate in the VIP ($n=40,419$).

Measurement

Use of hospital EDs and physician office visits was determined from Medicaid claims data. ED visits and physician visits were defined by CPT codes on HCFA-1500 claims and revenue codes on UB-82 claims. For each person in the study group and comparison group, we calculated the rate of use of hospital EDs and the rate of physician office visits before and after referral. To determine rates before and after referral for the comparison group, these persons were assigned artificial "referral dates" to correspond to the dates that the study patients had been referred to the VIP.

Data Analysis

Three analyses were performed. First, the change in rate of ED visits (from before to after referral) and the change in rate of physician office visits were calculated as continuous outcome variables. For each of the two outcome variables, the distribution for the study group was compared to the distribution for the Medicaid population. The Medicaid population included both the study group and the comparison group ($444 + 40,419 = 40,863$), since the intent was to test the null hypothesis that the study group was a random sample of the entire state Medicaid population. The Kolmogorov-Smirnov One-sample Test was used to test statistical significance.

Second, the two "change in rate" variables were converted to dichotomous outcome variables. Since the hypothesis was that the study group would decrease ED use and increase office visits, ED use was dichotomized into "decrease" vs "no decrease," while office use was dichotomized into "increase" vs "no increase." Using the chi-square statistic, the proportion of patients who had a decrease in ED use and the proportion of patients who had an increase in physician office visits were compared for the study group and the non-VIP comparison group.

Table 1

Characteristics of VIP and Comparison Populations

	VIP (n=444)	Medicaid Non-VIP (n=40,419)
Age (years)*		
0-4	27.3%	28.7%
5-14	23.0%	20.1%
15-24	13.7%	19.6%
25-44	28.1%	22.2%
45-64	8.0%	7.1%
Gender*		
Male	30.9%	41.0%
Female	69.1%	59.0%
Race*		
White	45.5%	35.5%
Black	49.3%	56.9%
Hispanic	3.2%	5.9%
Other	2.0%	1.7%
County of residence*		
New Castle	67.3%	58.9%
Kent	22.7%	20.1%
Sussex	9.7%	20.5%
Medicaid eligibility category		
AFDC	31.5%	79.9%
SSI	16.0%	18.3%
Other	2.5%	1.8%

VIP—Voluntary Initiative Program

AFDC—Aid to Families With Dependent Children

SSI—Supplemental Security Income

*P<.0001 by chi-square test for difference between groups

Finally, a multivariate analysis was conducted to adjust for potential confounding variables, using the two dichotomous outcome variables described above. Demographic patient variables (age, gender, race, county of residence, and Medicaid eligibility category) that differed for the study and comparison groups at $P<.1$ (by chi-square test) were entered as control variables. The Mantel-Haenszel weighted odds ratio (OR) was calculated along with 95 percent confidence intervals (CI).

Results

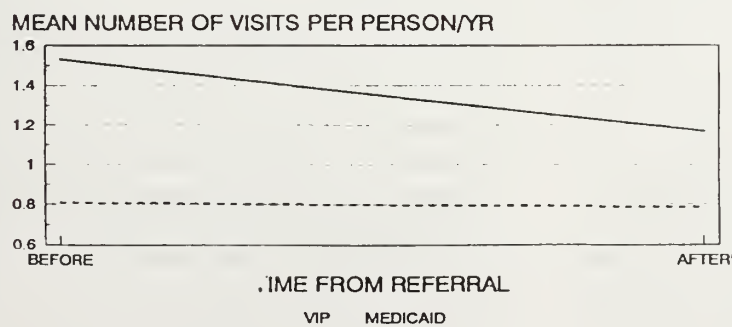
As shown in Table 1, both the study and comparison groups were primarily female and non-white, and about half were children under age 15. The study patients were more likely than the comparison population to be female, white, adults, and from New Castle County (the most urban of the three counties).

Figures 1 and 2 illustrate the change in use for the study group and the Medicaid population as a whole. After referral to the VIP, the study group decreased its ED use 24 percent, from 1.53 to 1.17 visits per person

per year. During the same time period, the Medicaid population decreased its ED use only 4 percent, from .83 to .79 visits per person per year ($P<.01$). Physician office visits increased 50 percent after referral for the VIP group, from 4.53 to 6.54 visits per person per year, while they decreased 13 percent for the Medicaid population, from 3.54 to 3.06 visits per person per year ($P<.01$).

These findings persisted when dichotomous outcome variables were used

Figure 1

Emergency Department Use Before and After Referral:
VIP Versus Medicaid Comparison Group

VIP—Voluntary Initiative Program

P<.01 for difference in change in use between groups by Kolmogorov-Smirnov One-sample Test.

(Table 2). A decrease in ED use was seen in 36 percent of VIP patients, compared with 26 percent of comparison patients (OR=1.62, $P<.001$). This finding persisted after adjusting for patient age, gender, race, and county of residence (adjusted OR=1.59, 95 percent CI=1.31-1.92). An increase in physician office visits was seen in 50 percent of VIP patients, compared with 25 percent of comparison patients (OR=3, $P<.0001$), which persisted after adjusting for control variables (adjusted OR=2.88, 95 percent CI=2.40-3.46).

Discussion

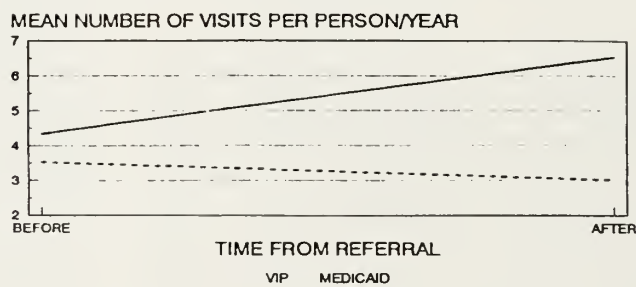
This study demonstrates a positive effect of referring Medicaid patients to a regular source of care. Medicaid patients who were referred through the VIP had a substantial decrease in the ED use and a substantial increase in physician office visits. These changes are consistent with the program's goals and were not seen in the rest of the Medicaid population. These changes occurred despite the absence of any managed care component to the program and despite any structured program to educate patients about appropriate use of health care services. Physicians in the program were not expected to act as gatekeepers or case managers for their referred patients. While some patients made appointments at the time of referral (44 percent), the VIP could not ensure that the patient actually saw the physician to whom they were referred. In fact, a separate analy-

sis revealed that only 48 percent of referred patients saw their referral physician, while approximately 20 percent saw another physician of the same specialty in the same geographic area.

The benefits of improved access to primary care have been suggested in previous studies. Several studies showed a decrease in ED use after establishment of community

Figure 2

Ambulatory Physician Visits Before and After Referral:
VIP Versus Medicaid Comparison Group



VIP—Voluntary Initiative Program

$P<.01$ for difference in change in use between groups by Kolmogorov-Smirnov one-sample test

Table 2

Change in Use of EDs and Physicians' Offices After Referral:
VIP Versus Non-VIP Comparison Group

	VIP (n=434)*	Non-VIP (n=39,533)*	Unadjusted Odds Ratio	Adjusted*** Odds Ratio (95% CI)
Percentage of patients with decrease in ED visits	36.4	26.1	1.62 ($P<.001$)**	1.59 (1.31-1.92)
Percentage of patients with increase in physician office visits	50.5	25.4	3.00 ($P<.001$)**	2.88 (2.40-3.46)

ED—Emergency department

VIP—Voluntary Initiative Program

*—Patients excluded if data on control variables is missing

**—By chi-square test

***—Mantel-Haenszel weighted odds ratio, adjusting for patient age, gender, race, and county of residence

health centers,¹⁸⁻²⁰ and other studies showed that patients with a regular source of care are less likely to use the ED.²¹ However, the effect of programs specifically designed to refer patients to primary care physicians have not been as encouraging.¹⁵⁻¹⁷ While these other programs have shown an increase in physician office visits after referral, they have not demonstrated any decrease in nonurgent ED use.

There are several reasons why the VIP may have led to a decrease in ED use while other programs have not. First, the VIP referral process was usually initiated by the patient, so this group may have been particularly motivated to change their health-seeking behavior. Other programs have often targeted nonurgent ED users, who may not be as motivated to change their patterns of use. Second, the VIP targeted only the Medicaid population, while other referral programs have not specifically examined this population. One way the Medicaid population may differ is that they have no copayments for health care services. Therefore, there is less financial disadvantage for them to use office-based physicians. People with other insurance or no insurance may be required to pay office-based physicians in advance or may be responsible for copayments; this may encourage them to use hospital EDs instead.

Several limitations to this study must be considered. First, because the VIP group and Medicaid patients may differ from other populations as described above, the results may not be generalizable to other referral programs, even within the Medicaid population. Second, we know that the VIP group differed from the comparison group on a number of variables. While we were able to adjust for some important demographic variables, other unmeasured variables such as educational status and ability to access transportation to health care facilities were not measured. Third, the VIP patients were higher users of health care services before referral. The decrease in ED use may be partly a result of regression to the mean, although this does not explain the increase in office visits. The higher use may also represent a greater need

for health care services (a future analysis will control for case mix). Fourth, while this study showed a decrease in ED use and an increase in office visits, we do not know the effect of these changes on the overall cost or quality of health care. Finally, this analysis looked only at the first six months of the program. While the changes seen are both statistically and clinically significant and while they are in agreement with the goals of the program, it remains to be seen whether the changes persist over time. A future analysis will examine whether the positive impact on use persists over the subsequent one to two years of the program.

Despite these limitations, this study has important implications for health care policy. A trend is taking place in this country toward a health care delivery system oriented to primary care. This is based on the assumption that such a system will lead to improved health and lower costs. One way to increase reliance on primary care is through managed care. However, many patients and providers are slow to accept managed care, and developing managed care networks may take a significant amount of time and resources, especially in areas that have little experience with this model. This is particularly true for Medicaid programs, where administrative hurdles are greater, and patients have historically relied on hospitals for basic care.

This study suggests that referral to a regular source of care can have benefits even without managed care. This model could be used by Medicaid programs that are not able to develop a managed care system or that are waiting to develop adequate networks of physicians or awaiting federal waivers. The benefits of primary care may be even greater once managed care is instituted. If ED use decreases simply as a result of referral to a primary care physician, then one would expect an even greater increase if this physician were to act as a gatekeeper for ED visits.

Finally, this study supports the importance of primary care in general and family practice in particular. It may seem intuitive to family physicians and others that increased reliance on primary care would lead to im-

provements in health care delivery. However, it is important that we not just accept this assumption, but test it by measuring the outcomes associated with primary care. This study demonstrates at least one positive outcome of improved access to primary care — a decrease in use of hospital EDs. Continuing research is needed to examine how primary care impacts other aspects of health care use, quality, and cost. ■

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Bugs and Bites

Dirk M. Elston MD, LTC MC

This paper was distributed as a handout by Dr. Elston at the Tuesday morning Update in Medicine Conference (hosted by the MCD Department of Medicine), at the Delaware Academy of Medicine on June 18, 1996. It can't convey the flavor and humor of the original presentation, which was outstanding, but nevertheless contains the useful information. Dr. Elston has graciously given permission to reprint it in DMJ so all our members may have access to it.

— EWM

Arthropods and Human Disease

The phylum Arthropoda includes insects, arachnids and crustaceans. Arthropods serve as vectors of viral, bacterial, rickettsial and helminthic pathogens. Crustacean larvae have been implicated as one cause of sea bather's eruption (other causes include sea anemone and jelly fish larvae). Bites and stings are the focus of this presentation.

Immune Responses to Arthropods

Immune responses present as papular urticaria, vesiculo-bullous lesions and persistent lymphoid infiltrates. The histologic spectrum of lymphoid arthropod reactions ranges from mild perivascular lymphoid infiltrates to pseudolymphoma.

Individuals who encounter a new biting insect often manifest a type IV (DTH) immune response. With continued exposure, immediate hypersensitivity reactions occur. With long-term exposure, immune tolerance may develop.

I have also noted individuals who progress from papular urticaria to pseudo-lymphomatous DTH responses over time.

Dr. Elston is a physician at Brooke Army Medical Center, Fort Sam Houston, Texas.

None of these individuals developed evidence of immune tolerance.

Arthropod Venom

Arthropod venoms may contain neural, cardiac, hemolytic and dermonecrotic toxins. Hyaluronidase has been identified as a "spreading factor" in brown recluse spider venom. Brown recluse venom also contains a 32 kd protein with sphingomyelinase D activity and chemotactic activity. Honeybee venom contains histamine, melittin, phospholipase A and hyaluronidase. Vespid (wasp) venom contains histamine, serotonin, kinins, a phospholipase, hyaluronidase, and an unidentified protein that appears to be the major allergen.

Treatment

Stings

Patients with a history of anaphylaxis from bee or vespid stings should carry epinephrine. Two types of epinephrine injector kits are commercially available. The ANA KIT contains a prefilled syringe for subcutaneous injection. The syringe can deliver two 0.3 mg doses of epinephrine. The kit also contains chewable chlorpheniramine tablets and a tourniquet.

A spring loaded epinephrine autoinjector is marketed under the names EPIPEN and EPIPEN JR. The EPIPEN delivers a 0.3 mg intramuscular dose of epinephrine. The EPIPEN JR delivers a 0.15 mg dose.

Bites

Topical antipruritics such as camphor and menthol act as counter irritants. Products include Sarna lotion and *Rhuli* gel.

In parts of Texas, topical application of Mennen Speed Stick has gained "cult status" as an antipruritic for chigger bites. The main ingredient in Speed stick is propylene glycol, which probably accounts for the counter irritant effect.

Topical, systemic and intralesional corticosteroids may be useful for the treatment of persistent delayed-type hypersensitivity reactions. Potent Class I and Class II steroids are often required.

Topical tar has been used for scabies nodules, although, in my experience, potent topical or intralesional corticosteroids achieve better results.

Protection

Protection against bites and stings includes avoidance and protective clothing. Repellents, including diethyl toluamide (DEET), dimethyl phthalate, dimethyl carbate, ethyl hexanediol, butopyronoxyl (Indalone), and benzyl benzoate have been used. Recently, the insecticide PERMETHRIN (PERMANONE) has been marketed as a tick "repellent." Permanone spray is applied to clothing, rather than skin. It is stable through several wash cycles. A discussion of repellents follows.

Safety of Repellents

Toxic reactions to DEET include toxic encephalopathy, especially in infants and children. Deaths have occurred. Anaphylactic reactions have also been reported. Ten to 15 percent of the dose of DEET applied may be recovered from the urine. "DEET dermatitis" is an irritant dermatitis of the face, neck and flexures. In my experience, it is associated with formulations containing a high percentage of DEET. A new long-acting DEET cream

has been developed for the military. It contains only 30 percent DEET. Dermatitis is much less of a problem with this product.

Recently, ethyl hexanediol has been implicated as a teratogen. *Texas Preventable Disease News*, August, 1992. The EPA has issued an advisory that the use of 2-ethyl-1,3-hexanediol by pregnant women may pose a risk of birth defects. The advisory is based on preliminary data from the manufacturer which showed possible teratogenic effects in test animals. No cases of human birth defects have been reported. Repellents containing ethyl hexanediol have been marketed primarily in the northeastern and upper midwestern states to repel black flies. Below is a partial list of products which contain ethyl hexanediol:

6-12 Plus Insect Repellent Stick
6-12 Plus Insect Repellent Liquid
Off! Insect Repellent IV
6100 Formula 2 Fly and Mosquito Repellent Gel
Johnson Wax 6017 Formula 10 Insect Repellent
BF-100 Blackfly Repellent Solution

Permethrin's mammalian toxicity appears to be low.

Efficacy of Repellents

Flying insects:

Long acting DEET cream/lotion (Ultrathon, Skedaddle, OFF, Skintastic). Permethrin treated clothing provide additional protection. According to the manufacturer, Ultrathon is marketed nationally by WalMart and Walgreen stores. It is also available from AMWAY under the name Hour Guard.

In a study conducted in Alaska, in an area with many mosquitoes and few mosquito-borne diseases, untreated subjects received bites at a rate of 1,188 per hour. A long acting DEET formula alone provided 99 percent protection for more than eight hours (4 bites/hr). Permethrin alone provided 93 percent protection (78 bites/hr). The combination of DEET and permethrin provided 99 percent protection (1 bite/hr).³⁵ Lillie, et al. *J Med Entomol* 25:475, 1988. Permethrin treated screens can be helpful. Basimike, et al. *J Med Entomol* 32(4): 428-432. A DEET/

permethrin soap has been studied, but provided relatively short-term protection. *Am J Trop Hyg* 52(2): 169-173, 1995.

Crawling arthropods:

Permethrin treated clothing. Long-acting DEET cream may provide added protection.

In an area of Cape Cod infested with *Ixodes scapularis* (formerly *I. dammini*), a one-minute application of permethrin provided 100 percent protection. One-minute applications of 20 percent and 30 percent DEET provided 86 percent and 92 percent protection, respectively. Schreck, et al. *J Med Entomol* 23: 396, 1986. North American ticks appear uniformly susceptible to permethrin. Some North African ticks are resistant. Permethrin may trigger an attachment response in resistant ticks, paradoxically increasing the incidence of tick bites. Fryauff, et al. *J Med Entomol* 31(1): 23-29, 1994. Permethrin is also effective against chiggers. Breeden, et al. *Am J Trop Med Hyg* 31(3): 589-592, 1982. Frances, et al. *J Med Entomol* 29(6): 907-10, 1992.

Treating the environment is also helpful. Removing leaf debris and applications of Carbaryl are helpful. Schultze, et al. *J Med Entomol* 32(5): 730-33, 1995. Schultze, et al. *J Med Entomol* 32(2): 205-208, 1995. Chlorpyrifos provides longer control than insecticidal soaps. Allan, et al. *J Med Entomol* 32(1): 16-20, 1995.

Fleas:

Treating environment appears superior to wearing repellents. Permethrin/methoprene products and boric acid can be helpful. Organophosphate and carbamate insecticides are also useful.

Powdered and granular boric acid appear to be effective "natural" alternatives, although long-term safety studies are still needed. Hinkle, et al. *J Med Entomol* 32(4): 424-427, 1995.

Skin-So-Soft

Skin-So-Soft bath oil (Avon) contains di-isopropyl adipate, mineral oil, isopropyl palmitate, dioctyl sodium sulfosuccinate, fragrance and benzophenone-11. Skin-So Soft repels *Ae.*

aegypti. However, the protection lasts only ten to 30 minutes. Rutledge LC, et al. *Mosquito News* 42:557, 1982. DEET formulations are more effective than Skin So Soft against biting midges. Magnon, et al. *J Am Mosq Control Assoc* 7(1): 80-82, 1991. The safety of repeated widespread applications of Skin-So-Soft is unknown. The major effect of the bath oil is that insect wings stick to it. Mineral oil would have a similar effect. Avon now markets other repellent products under the name "Skin-So-Soft."

Suggested Reading

Textbooks

1. Burnett JW and Crutcher AC: Viral and rickettsial infections. In *Dermatology*, second ed. Philadelphia, W.B. Saunders Company, 1985, p.724-738.
2. Mahmoud AA, Miller LH, Quinn TC, et al: Diseases caused by protozoa and metazoa. In *Cecil: Textbook of Medicine*, 18th ed. Philadelphia, W.B. Saunders Company, 1988, p.1856-1927.
3. McKoy KC and Moschella SL: Parasites, arthropods, hazardous animal, and tropical dermatology. In *Dermatology*, second ed. Philadelphia, W.B. Saunders Company, 1985, p.1731-1820.
4. Shope RE, Tesh RB, Eickhoff, et al: Arthropod-borne viral diseases. In *Cecil: Textbook of Medicine*, 18th ed. Philadelphia, W.B. Saunders Company, 1988, p.1814-1831.

Periodicals

1. Altschuler DZ and Kenney LR: Pediculicide performance, profit and the public health. *Arch Dermatol* 122:259-261, 1986.
2. Brandenburg K, Deinard AS, DiNapoli J, et al: 1 percent permethrin cream rinse vs 1 percent lindane shampoo in treating pediculosis capitis. *Am J Dis Child* 140:894-896, 1986.
3. Burgdorfer W, Barbour AG, Hayes SF, et al: Lyme disease - a tick-borne spirochetosis? *Science* 216:1317-1319, 1982.
4. Groff JW: Organisms and associated diseases. *Journal of the Association of Military Dermatologists* 9:72-75, 1983.
5. King LE Jr and Rees RS: Treatment of brown recluse spider bites. *J Amer Acad Dermatol* 14:691-692, 1986.
6. Kurgansky D and Burnett JW: Diptera mosquitoes. *Cutis* 41:317-318, 1988.
7. Miller JD: Anaphylaxis associated with insect repellent. *N Engl J Med* 307:1341-1342, 1982.
8. Modley CE and Burnett JW: Tick-borne dermatologic diseases. *Cutis* 41:244-245, 1988.
9. Sanus ID, Brown EB, Shepard TG, et al: Tungiasis: Report of one case and review of the 14 reported cases in the United States. *J Amer Acad Dermatol* 20: 941-944, 1989.

Lice, Mites and Arachnid Bites

Lice

Phthirus (Phthirus) pubis (the pubic or crab louse), *Pediculus humanus capitis* (the head louse) and *P. humanus corporis* (the body louse) are common human ectoparasites. Their eggs (nits) are found attached to hairs (or in the case of body lice, to fibers of clothing). Nits on the eyelashes are usually the result of crab louse infestation. Crab lice can also infest the scalp. Signor, et al. *Arch Dermatol* 125:133, 1989. Body lice transmit typhus, trench fever and relapsing fever.

Of potential medicolegal significance, Host DNA can now be identified in crab louse excreta by amplified fragment length polymorphism analysis. Replogle, et al. *J Med Entomol* 31:686, 1994.

Other lice, such as Psocoptera, may infest houses and cause scalp infestation. Reinfestation of the scalp will occur unless the home environment is treated. Coulthard, et al. *Br J Dermatol* 125: 400, 1991.

Treatment of body lice centers on treatment of the infected clothing. Laundering and ironing may be adequate, but is not always possible for those living under the worst of sanitary conditions. Poverty, war and natural disaster are natural settings for the spread of body lice. Treatment of infested clothing with DDT, permethrin, or fumigants has been useful in these settings. Single dose oral ivermectin shows promise as an agent for mass treatment of refugees. Dunne, et al. *Trans Royal Soc Trop Med Hyg* 85:550, 1991. Permethrin treated clothing has been shown to offer protection against body louse infestation, even after 20 wash cycles. Sholdt, et al. *Military Medicine* 154, 1 2:90, 1989.

Agents used to treat pubic and head lice should be effective against both adult lice and nits. Many schools have adopted a "NO NIT" policy, requiring mechanical removal of all nits before a child may return to school. In some cultures, monkeys are employed as patient and effective nit removers.

Permethrin (NIX) has proved to be an effective agent for the treatment of head and pubic lice. Brandenburg, et al. *Am J Dis Child* 140:894-896, 1986. It has been sug-

gested that pyrethrins and piperonyl butoxide (RID, A-200) and malathion may be more effective against nits than lindane. Altschuler and Kenney. *Arch Dermatol* 122:259-261, 1986.

Phthiriasis palpebrum can be treated with fluorescein dye, petrolatum or 1 percent yellow mercuric oxide ointment. Ashkenazi, et al. *Br J Ophthalmol* 75:356, 1991.

Eight percent Formic acid rinses (Step 2, nit removal system) are effective in removing nits. DeFelice, et al. *Int J Dermatol* 28: 468, 1989. This is important, because no current product is 100 percent cidal for nits, and complete nit removal using nit combs can take hours. Clore, et al. *J Ped Health Care* 7:55-660, 1993.

Piperonal spray (Rappell) shows promise as a head louse repellent to prevent reinfestation. Burgess. *Br J Dermatol* 128:357, 1993.

Other effective agents, generally not used in the United States, include carbaryl lotion and shampoo and phenothrin shampoo. Sexton, et al. *Curr Med Res Opin* 12:466, 1991. Jolley, et al. *J Roy Soc Health* 111:90, 1991.

Mites

Scabies:

The human itch mite, *Sarcoptes scabiei*, completes its entire life cycle on the human host. Infestation may therefore persist indefinitely unless an effective scabicide is used. All hosts develop scabies-specific circulating antibodies. Arlian, et al. *Exp Parasitol* 78:37, 1994. Sixty-five percent of hosts develop some evidence of acquired immune resistance to reinfestation. Arlian, et al. *Exp Parasitol* 78:51, 1994. The universal presence of circulating antibodies, even in non-resistant hosts, implies that resistance is a cell mediated phenomenon.

The adult female mite burrows through the stratum corneum to the level of the upper stratum granulosum. Lesions characteristically involve the webspaces, wrists, areolae, glans penis and umbilicus. The diagnosis is confirmed by the demonstration of an adult mite, eggs or feces in scrapings from a bur-

row. Fluorescent microscopy can be helpful in identifying mites and ova. Bhutto, et al. *J Dermatol* 20:122, 1993.

Norwegian (crusted) scabies may be seen in disabled, elderly, mentally handicapped or immunosuppressed patients. These patients are infested with innumerable mites and are highly contagious. Scabies may also mimic bullous pemphigoid, including light microscopic and immunofluorescent findings. Bhawan, et al. *J Am Acad Dermatol* 24: 179, 1991. Human infestation with animal scabies (mange) mites has been reported. Mitra, et al. *Trop Geo Med* 45:142, 1993.

Treatment

Treatments for scabies include permethrin (ELIMITE), lindane (K WELL), crotamiton (EURAX), and precipitated sulfur in petrolatum. Recently Kwell cream became unavailable, however, lindane lotion is still available from Goldline Pharmaceuticals. Lindane resistant scabies have been reported. Judd, et al. *N Z Med J* 106:61, 1993. Taplin, et al. *J Amer Acad Dermatol* 15:995-1001, 1986. Purvis, et al. *JAAD* 25:1015, 1991. Some cases of apparent "drug resistance" may be explained by failure to treat subungual mites and eggs. Witkowski, et al. *JAMA* 252:1318, 1984. Permethrin has been advocated as a superior first-line scabicide, especially in children and immunosuppressed patients. Paller. *Seminars in Dermatol* 12:3, 1993. Funkhouser, et al. *Arch Dermatol* 129: 911, 1993. Immunosuppressed patients may require repeated treatment with a single scabicide or the sequential use of different agents. Orkin, et al. *Seminars Dermatol* 12:22, 1993.

Lindane products may cause seizures if they are applied repeatedly. Aplastic anemia has also been reported after prolonged use. Rauch, et al. *Arch Intern Med* 150:2393, 1990. Permethrin has little known mammalian toxicity.

World-wide, many additional treatments have been used. Malathion is used in the United Kingdom. It is suitable for use during pregnancy. Barrett, et al. *Comm Dis Report* 3:32, 1993. A single oral dose of Ivermectin

can be effective. Kar, et al. *Nat Med J. India* 7:15, 1994. Single dose treatment with Ivermectin may be helpful in cases of mass infestation, such as among refugees of war or natural disaster. Glaziou, et al. *Trop Med Parasit* 44:331, 1993. Benzyl benzoate, used topically is also an effective treatment. Four of 15 Rwandese medicinal plants used in traditional Rwandese medicine have been shown to be scabicial. Heyndrickx, et al. *J Ethnopharmacol* 35:259, 1992. Ascabiol, a topical scabicide used in France, contains tetraethylthiuram monosulfide which is absorbed systemically and may produce a disulfiram-like reaction with alcohol ingestion. Blanc, et al. *Lancet* 335:1291.

Other Mite infestations

Chyletiella (walking dandruff) mites are a frequent cause of pet-associated dermatosis. Harvest mites (chiggers) cause bite reactions and transmit scrub typhus. Rat, bird and grocery mites can cause human disease. A high index of suspicion is needed. Larval mites frequently cause disease. The larval stage is identified by the presence of six (rather than eight) legs. Millikan. *Seminars Dermatol* 12:46, 1993. Blankenship. *Dermatol Clin* 8:265, 1990.

Arachnid Bites

(Spider bites and scorpion stings)

Brown recluse

Loxosceles reclusa is the spider usually associated with necrotic cutaneous reactions. *L. laeta* can produce similar lesions. Macchiavello. *Pub Health Trop Med* 22:266, 1947. Macchiavello. *Revta Chil Hist Nat* 41:11, 1937. These spiders are found throughout the Americas, but most bites are reported from Arkansas, Missouri, Kansas and Tennessee. The histologic changes seen in brown recluse bites resemble those of an Arthus reaction. Futrell. *Am J Med Sci* 304:261, 1992. Neutropenic rabbits are protected from necrosis, suggesting that neutrophils are central to the pathogenesis of the reaction. Endothelial injury is noted early in developing lesions. Subsequent thrombosis results in ischemic injury.

Brown recluse venom contains alkaline phosphatase, five ribonucleotide phosphohydrolase and hyaluronidase. None of these enzymes recreates the necrotic reaction, but hyaluronidase appears to be a spreading factor. Sphingomyelinase D, contained in the venom, can reproduce the necrotic lesions.

Treatment

Topical application of ice reduces inflammation. Application of heat may be detrimental. Antibiotic therapy may be indicated if secondary infection cannot be excluded. Dapsone has been advocated for treatment of brown recluse spider bites. Guinea pigs pretreated with dapsone prior to envenomation are protected from necrosis. The results of post-envenomation treatment are less dramatic, but dapsone appears to be a viable therapy for many patients. King, et al. *JAMA* 250: 648, 1983. Dapsone should not be given to G6PD deficient individuals. Systemic and intralesional corticosteroids and immediate local excision of the bite site have been advocated in the past. For local bite reactions, these treatments do not appear to offer any advantage over treatment with dapsone alone. King and Rees. *J Amer Acad Dermatol* 14:691-692, 1986. Systemic steroid therapy should be considered in systemic reactions. Anti-venom therapy has been used with some success, but it must be used within hours of the envenomation and is not readily available. Beckwith. *Toxicon* 18:663, 1980. Because thrombosis occurs early in the evolution of necrotic lesions, aspirin therapy has been suggested. Patients should be monitored for signs of systemic toxicity (hemolysis, renal failure, DIC). Systemic reactions frequently are associated with minor appearing wounds and may not become apparent until two to three days after the bite. Wilson and King. *Dermatol Clin* 8:277, 1990. Because DIC complicates some brown recluse bites, aspirin therapy is not without risk.

Black widow

Latrodectus mactans venom contains neurotoxins. Venom reactions mimic an acute abdomen. Narcotic analgesics, muscle relaxants and IV calcium gluconate have been used to treat venom reactions. A horse serum antivenom is available.

Tarantula

Members of the Theraphosidae family (Tarantulas) are large hairy spiders commonly found in the southwestern United States. Contact with the hairs commonly produces an urticarial reaction. Tarantulas are also capable of flicking bristles into the eyes of their enemies. Edwards. Spitting Spider from Hell. *Vet Hum Tox* 32:330, 1990.

Scorpions

Centruroides sculpturatus, found in Arizona is the only deadly scorpion found in the United States. Antivenom is available, but may result in serum sickness. Other treatment is largely supportive. The stings of other American scorpions are painful, but, except for allergic anaphylactic reactions, are not life threatening. Allen. *Emergency Med Clin* 10:269, 1992. ■

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Complications of Total Hip Arthroplasty

Leo W. Raisis MD

A recent report by the *American Journal of Public Health and the Agency for Health Care Policy and Research* (HSO6326) have recently reviewed the total hip arthroplasty experience in the United States from 1986 through July of 1989.

The incidence of complications in total hip arthroplasty was quite low. A specific subgroup of the study was of interest. A study of elderly Medicare patients showed that women had slightly higher total hip arthroplasty rates than men. Rates of arthroplasty increased in the 80 to 84 year old age group and then declined thereafter. Of specific note was the fact that the black population underwent hip arthroplasty at the rate of half of that of whites. It was unclear if this represented differences in the incidence of osteoarthritis in different racial groups or personal treatment preferences. Economic factors could be at least partially excluded due to the fact that all racial groups in this age group are covered by Medicare Insurance.

Specific data regarding the 80 to 84 year old age group showed that 2.5 percent of patients died within six months of the operation. And 3.5 percent died within one year. This mortality rate was not specifically assigned to complications of the procedure but may rather indicate the normal percentage of attrition in this age group. Mortality was higher in male patients and patients older than 74 years of age.

Additional hip surgery was performed in 1.8 percent of the total hip arthroplasty cases

within one year. A total of 3.2 percent had repeat surgery within two years and 4.2 percent had surgery within three years. Serious complications were uncommon. Fortunately, the infection rate was defined as less than 1 percent even after two years. Pulmonary embolism, still one of the most serious complications occurred in 2 percent of total hip arthroplasty patients within six months but rarely occurred thereafter. Therefore it appears that the high risk window for pulmonary embolism is within the six month period post surgery.

The sample consisted of 5,579 elderly patients in whom total hip arthroplasty was performed, in the absence of infection, fracture or previous hip surgery. Osteoarthritis existed in 83.3 percent of the patients undergoing total hip arthroplasty.

This rather accurate data provides information which should help primary care physicians in recommending total hip arthroplasty for their patients, as well as providing the operating orthopaedic surgeon data with regard to complication rates and the continuing effort to minimize the chances for problems post total hip arthroplasty. The report seems to indicate that serious complications are rare in elderly patients undergoing hip arthroplasty.

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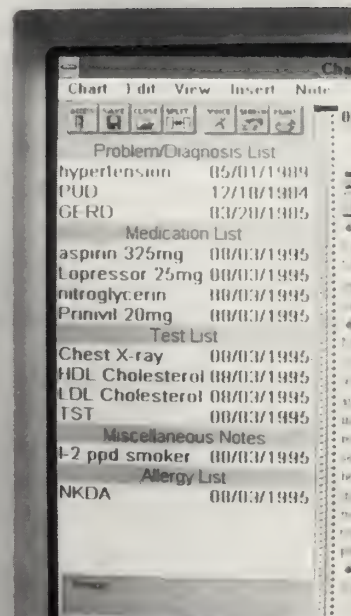
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AMA COMMITTEE REPORTS

Reference Committee A

These meetings dealt primarily with the financial aspects of medicine. Conversation indicated shared unhappiness with bureaucratic involvement in credentialing, volume discrimination and coverage of the insured and uninsured. There was also significant discussion on rural vs. urban reimbursement. Additionally, there was critical debate concerning the more recent problem of telemedicine. This discussion addressed the concerns of having a physician licensed in one state, giving opinion to a physician in another state. There was great consideration being given to the need for licensing in both states, in order to have a valid opinion registered.

The most significant discussion, from my perspective, was the argument between the internists and surgeons in reference to the onset and timing of the single conversion factor. The internists wanted the conversion factor to start immediately since a bill was sent to the president, and he vetoed it. The surgeons reminded the participants that in 1995, agreement was made, that there would be a three year onset once the law was passed and implemented. The discussion however, centered primarily around the fact that the internists seemed to be maneuvering so that their surgical colleagues would be affected more rapidly than they wanted to be. Suggestions were made by the surgeons that the American College of Surgeons left before, and might consider separating again, despite the fact that they had just recently come back into the fold.

I. Favel Chavin MD FACS

Reference Committee B

Board of Trustees 17 addressed the Nuclear Regulatory Commission's regulation of medical practice; the Board feels that the AMA should seek to legislate the end of federal regulation of byproducts of ionizing radiation, and incorporate that regulation into state programs.

BOT 25 recommends that AMA should determine whether physicians face unfair competition from tax-exempt health care entities, and report back on whether additional regulation is needed.

BOT 26 recommends model legislation for treatment of intractable pain, based on extant state laws, protecting physicians from disciplinary action, but also suggested specialty consultations be more extensively utilized.

BOT 32 addressed discounted insurance payments, stating that beneficiaries should be aware of the discounting, and that deductibles be based on the discounted payment. Congress should be lobbied to require this.

BOT 35 dealt with interpreter services; such services should be appropriately reimbursed, and the cost should not have to be borne by the physician.

Council on Medical Services Report 5 concerned monitoring Medicaid Managed Care, and was adopted with amendment, after very lengthy discussion. Provisions included elimination of hold harmless and gag clauses, education of beneficiaries to appropriateness of services, and case management for high utilizers.

Resolutions

Resolution 203 and 213 addressed constitutionality of patient data collection by clearinghouses and similar entities, and risks of breach of confidentiality; a substitute resolution that called on AMA to study this and report back to A-97. Resolutions 204 and 222, adopted with amendment, dealt with Medicaid coverage of long term care, balanced such that children covered by Medicaid are not disadvantaged. Resolution 205 sought malpractice insurance requirements for residents and students, but was referred. Resolutions 206 and 207 (substitute resolution adopted) addressed ERISA, liability and tort reform, citing recent circuit court rulings which did hold managed care organizations liable for injury related to their decisions. Resolution 209 sought freedom from CLIA, which AMA has been lobbying about for some time; it was adopted.

Substitutes 210 and 230 were adopted; these concerned emergency treatment and active labor, and asked for interpretation of the existing statute. Resolutions 211 and 225, regarding genetic testing and its ramifications regarding insurance coverage, were referred. Resolution 212 saw lengthy debate, and was adopted with amendment. It supported parity for psychiatry in benefits programs. Resolution 227, regarding use of social security numbers as provider identifiers, was referred.

Amended 228, which sought to ensure house staff receiving hepatitis vaccination, was adopted. Resolution 231, which asked for model legislation for physician self-governance in managed care entities, was adopted with amendment. Substitute 232, to reaffirm policy and enhance efforts on fraud and abuse legislation, was adopted.

Reference Committees C and G

The following resolutions were adopted. Resolution 301 Bioethical Decision Training for Residents - That the AMA encourage residency program directors to include training in bioethical decisions in all residency programs.

Resolution 303 Training of Residents in Outpatient Facilities - That the AMA propose changes in HCFA rules and regulations which would facilitate the appropriate training of

residents in non-hospital outpatient facilities.

Resolution 309 Instruction in Managed Care - That the AMA communicate with medical school deans and residency program directors urging the inclusion in their curricula of appropriate instruction regarding the concept, implementation and impact of managed care on the practice of medicine.

Resolution 310 Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment - That the AMA develop a plan of action to assist and protect medical students in the event of reduction in enrollment or closure of medical schools and that the AMA ask its representatives to the Liaison Committee on Medical Education to re-evaluate its existing guidelines on medical school closures assuring that medical school students are accorded maximum assistance and protection.

Resolution 311 Selection of Residents Based on Skill and Qualifications - That the AMA re-affirm its present policy that provides for residency selection on the basis of merit, skill and qualification.

Resolution 312 Resident Physician Licenses - That the AMA support the option of limited educational licenses in all states for resident physicians to provide care within their residency programs and that the AMA support reduced licensure fees for resident physicians for participation solely in graduate medical education training programs when full medical licensure is required by a state.

Resolution 313 Residency Program Responsibility for Resident Education - That the AMA affirm that the basic skills and competencies for the practice of medicine and its specialties must be determined solely by the medical profession.

Resolution 315 The Uniformed Services University of the Health Sciences. - That the AMA fully support the continuation of the Uniformed Services University of the Health Sciences as an institution and urge the executive and legislative branches of the United States government to fulfill their responsibility to our armed forces by fully funding the Uniformed Services University of the Health Services.

Resolution 317 Technology in Continuing

Medical Education - That the AMA set guidelines regarding circumstances in which new technologies can be used as acceptable methods of instruction to fulfill the criteria for either category I or category II continuing medical education credit toward the AMA Physician Recognition Award.

Resolution 319 Reduced Fees for Retired Physicians to Attend Continuing Medical Education Courses - That the AMA encourage all providers of continuing medical education to consider a reduced fee policy for retired physicians.

Resolution 323 Texas Hopwood Decision - That our AMA support the position of the state of Texas in appeals of the Hopwood decision.

Resolution 324 Support for Journal Based Continuing Medical Education.

Resolution 702 - Access to profile information - That the AMA develop and disseminate guidelines that would establish a fair, simple and timely process by which physicians can request and obtain any information about themselves and their practices that may have been developed and held by managed care organizations and other intermediaries in health care; and that the AMA ensure that such guidelines permit physicians to validate and correct misinformation contained within their "profiles."

Resolution 705 - Uniform Standards for Not-for-Profit and For-Profit Hospitals - That the AMA support the concept that all hospitals be held to the same standards of care, community service, professional education and commitment to their respective communities.

Resolution 711 - AMA policy and action plan on physician-purchaser relationships - That the AMA provide educational support and technical assistance to those physician groups considering global capitation contracts and/or direct contracting relationships with employers and also that the AMA develop and implement an action plan to help achieve these goals with a report back to the House of Delegates at the 1997 Annual Meeting.

Resolution 712 - Development of quality of care indicators for children with special health care needs in the National Committee

on Quality Assurance's Health Plan Employer Data and Information Set - That the AMA work with appropriate medical societies to urge the National Committee on Quality Assurance to develop performance measures for a broad continuum of childhood and adult chronic conditions.

Resolution 717 - Not-for-profit organizations developing for-profit subsidiaries - That our AMA undertake a study of activities by not-for-profit health care delivery institutions in creating corporations or other entities that compete with for-profit, tax-paying entities, including a review of various state rules and regulations governing the use of funds of for-profit subsidiaries, with a report to the House of Delegates on the results of this study.

Resolution 720 - "Managed Care" Definition - That the AMA through its Council on Medical Service review the subject and definitions of managed care and report back to the House of Delegates.

Resolution 724 - Managed Care Survey - That the AMA investigate mechanisms by which AMA members are asked to evaluate their satisfaction with managed care plans.

Resolution 726 - "Gag Clauses" - That the AMA continue to support any and all legislation to ban "gag clauses" from physician contracts.

Resolution 727 - Prepaid Prescription Plans Medication Substitution.

Recommendations of the following reports were adopted:

Report 2 of the Council on Medical Education - Compensation for teaching medical students and residents.

Report 3 of the Council on Medical Education - Reporting of malpractice information in the National Practitioner Data Bank.

Report 4 of the Council on Medical Education - Direct graduate medical education policy being considered by the Congressional Conference Committee on Medicare.

Report 5 of the Council on Medical Education - Reinstatement of full Medicare payment for second residencies in primary care or shortage specialties.

Report 6 of the Council on Medical Education - Content-specific CME mandated for licensure.

Report 7 of the Council on Medical Education - Restructuring of continuing medical education credits.

Report 8 of the Council on Medical Education - Physician appeals mechanism for denial of academic appointment.

Report 20 of the Board of Trustees - Improving medical schools/community practice relationships.

Report 23 of the Board of Trustees- Principles guiding AMA policy regarding supervision of medical care delivered by advanced practice nurses in integrated practice.

Report 30 of the Board of Trustees - Practice parameters and outcome management activities.

Report 34 of the Board of Trustees - National Committee for Quality Assurance.

Report 3 of the Council on Medical Service - Definition of "Principle Care."

Report 8 of the Council on Medical Service - Effects of Changing Practice Organization on Physician work effort and output.

Report 10 of the Council on Medical Service - Policy Consolidation in Physician-Specific Health Care Data.

Report 11 of the Council on Medical Service - Peer Review organization Program Status.

Report 12 of the Council on Medical Service - Financial Performance of Managed Care Plans.

Report 13 of the Council on Medical Service - URAC National Network Accreditation Standards.

Reference Committee D (Public Health)

This committee considered a multitude of public health issues. Particularly hot topics included HIV testing, Federal Block Grants for Public Health, Standards for Preventative Services, and Anti-Smoking Policy.

HIV issues included support for mandatory HIV testing of semen donors. The Council on Scientific Affairs Report 6 was approved. This report noted that the FDA recently approved a home blood test collection kit for HIV and recommends AMA policy that would encourage face to face counseling and testing. It also recommends the monitoring of their use and efficacy. Following heavy

debate the House voted to support the resolution for mandatory HIV testing of pregnant women.

The House referred several items to the Board of Trustees for additional study. One such item was an evaluation of winter sports safety and the use of protective head gear. Also referred was a study to examine the problem of errors in health care, and the policy of mandatory Varicella vaccine for health care workers.

The House supported a Medicine/Public Health Initiative which included an annual public health forum during the Interim Meeting. With the increasing use of Federal block grants for public health, a policy was adopted to encourage state and county medical societies to participate in deliberations for funding and utilization of these resources at the local level. There was much debate regarding the use of various guides to preventive services. One such guide that was thought to be of merit is the United States Preventive Services Task Force "Guide to Clinical Preventive Services, Second Edition." Because of the lack of agreement on many topics, this item was referred to the Board for further evaluation.

Medical issues related to violence in our society were addressed through several reports and resolutions. The Board of Trustees annual update report pledges to continue anti-violence efforts. Uniform opposition to extreme fighting was expressed by a resolution to prohibit media broadcasting of these events. The use of handguns was debated but no new policy was developed.

Tobacco related items included a resolution to urge physicians to avoid magazines in their waiting rooms that advertised tobacco products. A policy of tobacco-free psychiatric facilities was encouraged. Also adopted was a policy to discourage medical schools from accepting research funds from the tobacco industry and urge scientific publications to decline publishing such funded research. Support for physician and community divestment of tobacco stocks and mutual fund holdings was reasserted.

Another interesting resolution that was supported was for the development of stan-

dards for the provision of medical care on cruise ships.

Robert G. Altschuler MD

Reference Committee E

I had the privilege of being appointed to serve on this reference committee and served with very active, intelligent, knowledgeable and nonverbose members who were in rather complete agreement with the majority of this report.

A great deal of discussion was engendered regarding the diagnosis and treatment of attention deficit hyperactive disorder in school-aged children. During the course of the discussion, it was brought out that the American Academy of Child Psychiatry offered aid in any further studies in this regard and it was fairly well established that the diagnosis of attention deficit disorder is being over used and should include adults as well as children. The final decision and recommendation of the House of Delegates was that these further studies be coordinated, particularly with the American Academy of Child Psychiatry. A recommendation that Thiamin or Allithiamin be added to alcoholic beverages in order to reduce the incidence of Wernicke-Korsakoff syndrome was withdrawn by the Council of Scientific Affairs since apparently a statement from the government was due within a few days addressing this issue.

The House of Delegates voted, in regard to skin cancer self-examination, to encourage all physicians to perform self-examinations of the skin and to at least examine themselves and their families on "Melanoma Monday", on the first Monday of May and to urge all physicians to encourage their patients to perform regular skin self-examinations and to assist their partners to do so.

In regard to latex allergy warning, it was recommended and passed that the American Medical Association support the appropriate labeling of latex-containing medical devices with warning about possible allergic reactions, and it was further resolved that the AMA, along with interested medical specialty societies, review and comment on the Food and Drug Administration proposed rule concerning user labeling for latex-containing

medical devices. It was further noted that the Food and Drug Administration plans to publish a proposed rule requiring the addition of warning labels to all devices containing natural latex in the Federal Registry of 24 June, 1996.

It was suggested and recommended that rather than the AMA initiating its own study, it would be more expedient for the AMA, along with interested medical specialty societies, to review and comment on the FDA proposal.

The resolution regarding Dioxin and medical waste incineration noted that there was imminent publication of an FDA proposal in regard to this problem, and it was felt in view of both the information already available and the imminent publication of the FDA proposal, that rather than initiating its own study it would be more expedient for the AMA, along with interested medical specialty societies, to review and comment upon the FDA proposal.

With almost unanimous consent, resolution regarding standard policies and procedures for certifying indigent patients was approved and it was noted that despite problems, free drug programs for the indigent were praised wholeheartedly and the pharmaceutical industry was commended. It was further recommended that physicians can enhance these efforts by voluntarily declining to receive noneducational promotional materials and by urging that the funds otherwise spent on such materials be redirected to support expanded free drug programs for the indigent.

The situation of off-label indications for drugs and technologies for catastrophic illness was discussed at length. It was felt by the Reference Committee and accepted by the House of Delegates, that it is important to ensure that medical products are both safe and effective and the concept that the risk/benefit ratio must be considered. It was recommended that this be referred to the Board of Trustees for further study.

A great deal of testimony was heard extolling the merits of the AMA's previous efforts in the arena of "animals and biomedical research." The AMA was urged to utilize both

its existing materials and those excellent materials that have been developed by groups such as Connecticut United For Research Excellence and others in a renewal of its activities in this area with a focus on elementary school education. It was further brought to the attention of the AMA that threats of direct personal violence against biomedical researchers continue to be made.

The issue of use of restraints of patients in nursing homes was thoroughly discussed and it was noted that the Food and Drug Administration recently issued regulations governing the manufacture, design and labeling of personal restraints.

Under these circumstances, it was felt that further study was warranted before any changes in applicable regulations or laws were pursued.

Perhaps the greatest amount of discussion was engendered by the resolution regarding the expansion of AMA policy on female genital mutilation. It was called to our attention that this was becoming an increasing problem in the United States. It was recommended that physicians who are requested to perform female genital mutilation, instead provide culturally sensitive counseling intended to educate the patient and her family members about the harmful health consequences of the procedure and to discourage them from having the procedure. There was a considerable amount of discussion regarding criminalization of this procedure. The Reference Committee recommended that this not be criminalized, however, the House of Delegates felt that this should come under provision regarding child abuse.

James Marvil MD

Reference Committee F

Board of Trustees Reports

BOT 37, recommending no dues increase in the next two years, was adopted. BOT 31, examining WHO policy and essentially supporting it, was adopted with amendment. BOT 47, on AMA billing system, was filed.

Resolutions

Resolution 601, proposing reference commit-

tee reports with summaries of each item as a consent calendar, will be tried as a pilot for selected reference committees, at I-96. Resolution 603, seeking dues reduction for members of both AMA and AOA, was not adopted, and neither was 604, which suggested another meeting for state society presidents, in addition to OSMAP. Resolution 608, suggesting enhanced education of reference committee members in advance, was adopted. Resolution 610, seeking that the AMA work with MGMA to develop a membership category for medical group administrators, was adopted with amendment. Resolution 611, advocating more publicity of free clinics, was aborted, as was 612, with amendment, which supported continued publicity about medical savings accounts. Resolution 613, adopted with amendment, advocated an action plan to study and improve communication between AMA and individual members. Resolution 614, requested student and resident representation on the AMPAC Board. This will be implemented with a report on how at I-96. Resolution 617, The Board will report back on a study of direct membership in AMA, and the impact its discontinuation might have. Resolutions 618 and 622 addressed medical association credentials verification efforts, with concern that AMA not compete with local efforts. The consensus was to partner in such endeavors. Resolution 619 concerned a uniform application and credentialing form; AMA will examine existing instruments and help develop one. Resolution 623 addressed misinformation of the public by non-physician groups implying/stating capability to provide patient care. The House adopted the recommendation to continue to develop programs to educate the public on the differences between physician and non-physician health care providers.

Reference Committee H

A strong statement was given by the House of Delegates that the Joint Commission on Hospital Accreditation adhere to its own standards, specifically to strongly advocate that the Joint Commission consistently enforce its standards regarding unilateral amendment of

Medical Staff Bylaws and that hospitals found to have made unilateral changes to the Medical Staff Bylaws be cited for a serious violation of Joint Commission standards which may lead to loss of accreditation if the violation is not rectified within a specified time frame. The House of Delegates recommended, as a very high priority, that organized medical staff be included as a requirement for accreditation by private organizations of managed care plans, integrated delivery systems/networks, provider sponsored organizations and other organizations delivering health care. It was further recommended that the AMA increase its efforts to include this requirement of an organized medical staff for managed care plans in federal and state regulation and/or legislation.

As a result of the testimony and deliberations of the House of Delegates, it was recommended that the Health Care Financing Administration periodically review and address all three components of the RBRVS: the physician work component, the practice expense component and the professional liability component.

In regard to remuneration for physician services, it was recommended and passed that the American Medical Association actively support payment to physicians by contractors and third party payors for physician time and effort for providing case management and supervisory services including, but not limited to, coordination of care and office staff time spent to comply with the third payor protocols.

It was brought to the attention of the House of Delegates that the Health Care Financing Administration is not able to provide adequate data by January 1998 to implement resource based practice expenses. It was recommended and passed that the implementation of Medicare Fee Schedule Resource-Base Practice Expense Relative Values be delayed until January 1, 1999. In addition, the AMA Board of Trustees was advised to provide a progress report at the 1997 annual meeting in this regard.

Many of those testifying in regard to documentation requirements for physician care plan oversight, reported the notion that

it was more difficult to comply with the documentation requirements for care plan oversight than it was to provide the service, but there was no compensation for these services. It was recommended that the AMA continue to work with HCFA in regard to these documentation requirements.

It was called to the attention of the House of Delegates that the National Practitioner Data Bank was reporting disciplinary actions that had been overruled and it was strongly supported that these overruled disciplinary actions be removed from the National Practitioner Data Bank. Significant testimony was heard regarding confidentiality of patient records in view of computerized patient histories, and it was felt that the concerns of patient confidentiality and security of data are of paramount concern.

Considerable testimony was heard in regard to the recent HCFA policy requiring diagnosis for every test and chemical profile. It was recommended that the American Medical Association work with the Health Care Financing Administration to develop a policy for justification of chemical profile tests, including organ and disease oriented panels of laboratory tests that is nonintrusive to physicians and patients and enable physicians to submit all of the necessary ICD-9CM codes on a single health insurance claim form. It was further recommended that the report on these issues be developed for a report back to the House of Delegates at the Interim 1996 meeting.

James Marvil MD

Reference Committee I

At this year's House of Delegates meeting, the House voted for historic changes to be made to the structure and function of the AMA and the federation of Medicine. It is hoped that these changes will bring about a unification of the Medical profession which can allow the profession to speak to the public and the government with a single voice. It will also provide for greater representation in the House of Delegates of specialty societies and create a mechanism whereby physicians are better represented in the AMA/Federation of Medicine according to

their mode of practice (solo, group, salaried, etc.) and by ethnic and/or gender preference.

These changes will be accomplished with the aid of a transition team (Federation Coordination Team). This transition will take at least four years. The recommendations that were formulated by the consortium to study the Federation of Medicine as amended by the House of Delegates are as follows:

Recommendation 1:

That a Federation Coordination Team be established to achieve the functions endorsed by the AMA/Federation House in Policy 545.960, which are to clarify roles and achieve active coordination of efforts in the Federation and to establish a process for pursuing collaborative efforts among Federation members.

Recommendation 2:

That the life span of the Federation Coordination Team be three years, reflecting the expectation that the AMA/Federation Board of Trustees will assume the responsibilities of the Federation Coordination Team at the end of the Team's tenure.

Recommendation 3:

That the Federation Coordination Team be composed of 20 individuals and that these individuals be selected in the following manner:

- a) the Chair of the Study of the Federation, Dr. Joseph T. Painter, appoint a Selection Committee of five individuals chosen from the members of the current Project Team, the Consortium and the House of Delegates. These appointments shall be approved by the AMA Board of Trustees.
- b) the Selection Committee will appoint the individuals to serve on the Federation Coordination Team. These appointments shall be approved by the Board of Trustees. The members of the Selection Committee cannot appoint themselves to the Federation Coordination Team;
- c) some of the members of the Coordination Team (not to exceed five) be drawn from the current members of the Project Team to provide for continuity in implementing

the recommendations of the Study of the Federation; and

- d) the FCT be as representative as possible of the broad diversity of the Federation and its physician constituencies, including such dimensions as age, gender, and career stage (i. e., medical student, resident, young physician).

Recommendation 4:

That the AMA/Federation Board of Trustees select, from among the members of the Federation Coordination Team, an individual to serve as the Chair of the Team and that the AMA/Federation Board of Trustees appoint individuals to fill any vacancies that may occur on the Team.

Recommendation 5:

That the AMA/Federation Board of Trustees work closely with the Federation Coordination Team so that the Board is in a position to assume responsibility for the functions of the Coordination Team at the end of the three-year tenure of the Team.

Recommendation 6:

That the Federation Coordination Team report to the AMA/Federation Board of Trustees and that the FCT communicate regularly about its work to the AMA/Federation Board, the AMA/Federation House of Delegates, and the other organizations which comprise the Federation of Medicine.

Recommendation 7:

That during the tenure of the Federation Coordination Team, all Federation units represented directly in the House of Delegates, as well as county societies, be requested to provide financial support to the FCT's activities through annual contributions based on their total membership levels.

It is expected that the Federation Coordination Team will function with a modest budget. Current estimates are that large societies (10,000 members or more) would be assessed \$1,000 per year for the three-year life span of the FCT; societies between 5,000-9,999 members, \$750/year; societies between 2000-4,999 members, \$500/year; staffed

societies under 2000 members, \$100/year; the AMA, \$65,000/year; and non-staffed county societies would be solicited for contributions but on a voluntary basis. The recommended size and selection process for the FCT is designed to produce a workable approach, assure broad Federation representation, a sound mix of expertise, and continuity with the Federation Study.

It is expected that in doing its work, the FCT will reach out and invite participation by representatives of Federation units in specific projects that are developed to test ideas and approaches to achieving the overall goal of increased coordination and efficiency within the Federation. In addition, the FCT will work closely with the AMA/Federation Board of Trustees so that a smooth transfer of responsibilities is possible at the end of the three-year startup period.

Specialty Society Representation

Specialty is the principle medical identity of most physicians. Over the past fifty years, specialties have increased in number as the base of medical knowledge has exploded, driving commensurate growth in the number of specialty societies representing those interests. In the late 1970s, specialty societies became voting members of the AMA House of Delegates, reflecting their increased level of activity and stature in organized medicine.

As the Federation Study addressed how best to achieve the characteristics of inclusivity, balance, representativeness, and coordinated action on behalf of members, specialty representation was one of the most difficult dimensions. Clearly, specialty societies have a far more prominent presence in the health sector than in the past. They are a principle source of continuing medical education for physicians, and enjoy strong membership support. If the Federation is to be truly representative of both the interests of physicians and of the universe of physician organizations, an increased presence and role for specialty societies in the AMA/Federation must be achieved.

However, there are concerns about redundancy of representation stemming from the existence of multiple specialty organizations within many specialty disciplines. In

addition, there were questions about whether the specialty societies want or need more representation, and if so, how much. Concern also has been expressed about whether specialty societies ever would feel the need to be as supportive of Federation membership and advocacy efforts as other Federation units. And finally, some concern was expressed about the differences in organizational culture related to decision processes and opportunities for grassroots participation.

The Consortium and Project Team grappled with these various dimensions of the specialty representation question at some length. Since the 1995 Interim Meetings, there has been additional information gathering and dialog with the Federation on this topic. The Project Team has fashioned a response to specialty representation that responds to the needs of the Federation and addresses the key issues that the Project Team was asked to consider.

- It does not disenfranchise any of the specialty societies currently represented in the House of Delegates.
- It recognizes the significance of specialty society roles and stature in the health sector.
- It provides a way to "equalize" the differences in the number of specialty organizations in various specialty disciplines (i.e. compensate for redundancy), and at the same time maintain the direct participation of specialty organizations in Federation decision processes.
- It links membership to the representational process and provides an avenue of regular accountability back to grassroots members who are the ones that annually make a specialty society representational choice through a balloting process.
- It provides an annual communications opportunity with members that can be used to reinforce their "connection" with the Federation.
- It provides incentive for specialty societies to promote increased membership throughout the Federation as a means of enhancing their role and presence in decision processes.

It provides a phased approach to implementation that will enable all affected components of the Federation to adjust in a controlled manner.

Recommendation 8:

That the number of AMA delegate positions allocated to the specialty societies in the AMA/Federation House be determined in the following manner.

- a) Once a year, the AMA will send a specialty-representation "ballot" to each AMA physician member, plus fourth-year medical student members, asking each member to identify on the ballot one specialty society to represent him or her in the AMA/Federation House of Delegates for the next year.
- b) The specialty-representation ballot will indicate that physicians should be members of the specialty society which they select on the ballot to represent them in the AMA/Federation House of Delegates;
- c) For the first three years the number of delegates and alternate delegates allocated to a specialty society will be on the basis of one delegate and one alternate delegate for each 2000 AMA members, or portion of 2000 AMA members, who select that particular specialty society on the annual ballot and return the ballot to the AMA;
- d) Starting the fourth year the number of delegates and alternate delegates allocated to a specialty society will be on the basis of one delegate and one alternate delegate for each 1000 AMA members, or portion of 1000 AMA members, who select that a particular specialty society on the annual ballot and return the ballot to the AMA; and
- e) Each specialty society that meets the eligibility criteria and is represented in the AMA/Federation House be allocated at least one delegate and alternate delegate position regardless of the number of AMA members who select the society on the ballot and return the ballot to the AMA.

Recommendation 9:

The first specialty-selection ballot be distributed in the fall of 1996 and the resulting data be used to determine the number of delegates and alternate delegates which will be allocated to specialty societies for the 1997 Annual and Interim Meetings.

Appendix B provides statistical information on specialty representation based on this approach. Because specific specialty society delegate strength would be determined by balloting, specific society-by-society estimates cannot be made. Total maximum potential specialty society strength in the House can be estimated however, and is included in the material.

Recommendation 10:

That the Council on Long Range Planning study the current criteria that specialty societies must meet to be granted and retain representation in the AMA/Federation House, as well as the processes through which specialty societies apply for representation in the AMA/Federation House, in order to determine if changes in those criteria and processes should be made in light of the new approach to specialty representation recommended in this report.

Representation by Mode

of Practice and Other Characteristics

At the 1995 Interim Meeting, the House of Delegates endorsed the concept that the composition of the House of Delegates should "reflect the major dimensions of a physician's life." Geographic location and specialty are two of those dimensions, and are relatively easy to address in terms of an approach to representation. The other key dimensions, mode of practice, demographic characteristics, ethnicity, cultural, etc., are much more difficult to "capture" in an organizational sense, because they are less self-defining (e.g., what are the appropriate categories for mode of practice and how permanent are they?). In addition, this must be approached on a dual track; where organizations already exist that represent these interests, consideration should be given to providing opportunity for direct participation, but where such organiza-

tions do not already exist, new mechanisms may have to be created for that purpose. Either way, this is an exploratory and evolving process.

The Project Team explored how to best provide opportunity for these groups to express an interest in Federation participation while leaving flexible the particular mechanism through which such participation might best be accomplished. It is clear that this dimension of the new Federation will have to evolve in response to changing needs and interest levels.

Recommendation 11:

That, in order to implement Policy 545. 960, which states that the House of Delegates should be composed of organizations that reflect the major dimensions of a physician's life, the AMA/Federation Board of Trustees, organize hearings and/or engage in other forms of active outreach to special-interest physician organizations and mode-of-practice organizations to solicit their views on the best way of encouraging their active participation in the new Federation of Medicine; and that the Board of Trustees, with support from appropriate Council and Sections, use the input from these outreach efforts to identify the best approach to incorporating special-interest medical associations (ethnic, cultural, demographic, minority, etc.) and mode of practice organizations (group practices, managed care organizations, solo physicians, physicians in medical teaching, research physicians, physicians in administration, etc.) into the AMA/Federation House of Delegates.

Clearly, this is an exploratory undertaking. The findings from this outreach and analysis will be brought back to the House of Delegates for further consideration

Recommendation 12:

That the AMA/Federation House of Delegates offer a voting seat to each of the following organizations: National Medical Association, American Medical Women's Association, and the American Osteopathic Association.

There are currently three organizations with "observer" status in the House of Del-

egates whose constituencies are primarily physicians. Consistent with the intent that the new Federation be characterized by inclusivity, it is recommended that they be offered voting privileges in the House.

Recommendation 13:

That the AMA/Federation Board hold hearings and/or engage in other forms of active outreach to segments of the membership (women physicians, solo practice, IMG's, minority physicians, physicians in research, employed physicians, etc.) to solicit their input on how they could participate actively in the AMA/Federation; and that the Board of Trustees, with support from appropriate Councils and Sections, use the input from these outreach efforts to identify mechanisms and processes on how active participation by such groups can best be achieved.

Where physicians' interests are not already addressed by organizations a different approach will be required. A very flexible approach is needed that would facilitate discussion among physicians with similar interests and enable the AMA to provide focused information and outreach to such physicians. It will be important to have conduits through which the individual member can participate in and provide input to the AMA.

Achieving Common

Voice and Coordinated Impact

The goal of speaking with a common voice and achieving coordinated impact was the principle stimulus for the Council on Long Range Planning's recommendation that the Study of the Federation be conducted. In the research done early in the study, this goal surfaced again as a key expectation of physicians. It is one of the principle reasons physicians keep saying organized medicine should "get its act together." It was prominently built into the design criteria that define the characteristics of the new Federation.

The Project Team discussed this at length and offers the following recommendation as a starting point.

Recommendation 14:

That the AMA/Federation House of Delegates acknowledge the need for a "statement of collaborative intent" that respects the autonomy of constituent organizations, but also characterizes the nature of the working relationships that must exist among all members of the new Federation if it is to achieve its objectives, and that the Council on Judicial and Ethical Affairs and the Council on Long Range Planning and Development work together to develop and recommend such a statement. The statement should address such topics as:

a) promoting trust and cooperation throughout the Federation of Medicine; b) striving to help the Federation of Medicine speak with a unified voice, particularly on critical issues relating to patient care; c) working cooperatively with other Federation organizations to advance the image of physicians, the medical profession, and the Federation as a whole; d) supporting, whenever possible, the policies established by the AMA/Federation House of Delegates, and providing prior notice to other Federation organizations when public opposition to the policy positions established by the AMA/Federation House of Delegates is necessary; e) openly sharing information that can help other Federation organizations succeed, especially information that helps the Federation be responsive to member needs; f) working with other Federation organizations to minimize duplication of services, increase efficiency in organized medicine, and provide the best possible value to members through reduced dues and enhanced service; and g) working cooperatively with other Federation organizations to achieve better communications among physicians, between physicians and their medical association, and among the organizations which comprise the Federation of Medicine.

One of the dimensions of organized medicine in which unity is difficult to maintain is advocacy. The design of the new Federation acknowledges the continued autonomy and independent identity of the organizations that comprise it. There is a recognition that AMA/Federation House of Delegates policy cannot be binding on con-

stituent organizations. And yet the need for consistency and mutual support in public advocacy as well as other activities increasingly compelling. This was an issue of specific concern that was raised at the 1995 Interim Meeting in the context of specialty representation. It is obvious that individual societies are often subject to constituency pressures that drive policy positions that are not fully consistent with AMA House policy. But there is the need to do more to minimize those situations and do even more to close gaps where they exist or threaten.

Recommendation 15:

That the organizations represented in the AMA/Federation House of Delegates, recognizing the special need for coordinated action with regard to public policy activities, agree that they will:

- a) work toward what they believe to be in the best interest of all patients and physicians;
- b) share information and knowledge on key public policy issues so that everyone can build on it in seeking solutions;
- c) take established AMA/Federation House of Delegates policy into consideration as each element of the Federation develops its own policies and positions; and
- d) communicate regularly and openly, and share with each other, in advance, positions and public statements which represent major departures from AMA/Federation House of Delegates policy, and actively work to find acceptable common ground before agreeing to disagree.

One of the effects of a more diverse House of Delegates will hopefully be a policy development process that reflects the broadest possible diversity of interests, and thus generates policy that addresses the needs and concerns of all Federation participants. If this is the case, situations in which Federation organizations are inclined to not support House of Delegates policy will be minimized.

Enabling Steps:

Most of the recommendations in this report call for changes in representational ap-

proaches. Collectively, these recommendations constitute "enabling steps" that will make it easier for real collaboration to take place, by setting the stage for changes in how we work together as a total team. These changes will, over time, help the Federation to extend its culture of openness and creativity to meet the challenges of the emerging environment.

Building a truly effective framework for organized medicine is likely to require changes in governance, mechanisms, and processes. The specific changes in the governance structure will be implemented through the normal mechanisms that have always been used for such purposes. Where Bylaws changes are needed, the Council on Constitution and Bylaws will be asked to draft appropriate language for consideration by the House of Delegates. Where additional developmental work is needed, appropriate councils or the Board will undertake those tasks. The recommendations in the report identify the specific implementation agents wherever possible.

When dealing with changes of this magnitude, there are always considerations that have not been anticipated. As they surface, they will be addressed by the appropriate elements of the AMA or other Federation units.

Recommendation 16:

That the AMA Bylaws be modified to be consistent with the recommendations presented in this report and the actions of the House of Delegates on Board of Trustees Report 40 (I-95).

The proposed changes in the governance structure will require bylaws modifications through the usual mechanisms and will be subject to approval by the House of Delegates. In addition, the representational mechanisms evolving from recommendations 11, 12 and 13 of this report will need to be developed to allow all physician organizations and special physician groups to become participants at an appropriate level. Where an organization's bylaws are in conflict with the AMA bylaws, the organization may choose to change its bylaws or the AMA may

choose to grant a special exception to permit representation.

Recommendation 17:

That the recommendations of this report be adopted in lieu of recommendations 17, 18, 19, 21 and 22 of Board Report 40 (I-95). "Report of the Study of the Federation" and the remainder of the report be filed.

Summary

The preceding analysis and set of recommendations is the product of over two years of work by more than 200 individuals, all driven by the same goal: to design a Federation of Medicine that will be able to meet the challenges of the future and be worthy of the support of the physicians of America. Following the 1995 AMA Interim Meeting, the Project Team was encouraged by the openness of debate, the understandings reached, and the ultimate progress that was made. In addressing the issues that were referred back for further consideration, the Project Team took seriously the diverse input that was provided at the Interim Meeting and subsequently, and worked within the framework of the two years of deliberations that took place in the Consortium.

The Project Team believes that this report addresses the issues and provides sound responses to them:

- It provides a way to achieve, in practical ways, the more collaborative approach that physicians have indicated they expect from their medical associations;
- It provides a way to position the Federation to assist physicians as they cope with the changing environment.
- It provides a way to reduce cost and enhance value to members;
- It positions the Federation to be future oriented and proactive in its activities;
- It provides a way for the Federation to be inclusive, while at the same time maintaining a manageable decision making process; and
- It provides a basis for the trust that is needed to forge a Federation that has the strength to hold together in the face of pressures to divide it.

What remains is to understand and acknowledge the urgency with which this vision must be pursued, and then act on it. ■

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NEW MEMBERS

NEW CASTLE COUNTY NEW MEMBERS 7/23/96 (* = Pending Member)

E. Stanton Adkins, MD

Dept of Surgery, PO Box 269, Wilmington 19899
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General Surgery (1992)
Columbia University College of Physicians and Surgeons, New York, 1984

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4755 Ogletown-Stanton Rds, PO Box 6001, Newark 19718
Emergency Medicine
Jefferson Medical College of Thomas Jefferson University, Philadelphia, 1991

David M. Cohen, MD

J-32 Omega Dr, Newark 19713
Infectious Disease (1994)
Internal Medicine (1992)
Jefferson Medical College of Thomas Jefferson University, Philadelphia, 1989

Evan H. Crain, MD

Ste 600, MSB St Francis, 7th & Clayton Sts, Wilmington 19805 Ste 303, 550 Stanton-Christiana Rd, Newark 19713
Orthopaedic Surgery
Sports Medicine
New York University School of Medicine, New York, 1989

Tony R. Cucuzzella, MD

Ste 541, 501 W 14th St, Wilmington 19801-1013
Phys Med & Rehabilitation
Tulane University School of Medicine, New Orleans, 1990

Denise DiPrimo-Kalman, DO

A.I. DuPont Institute, 1600 Rockland Rd, Wilmington 19899
Allergy & Immunology (1995)
Pediatrics (1990)
Philadelphia College of Osteopathic Medicine, Philadelphia, 1986

Valerie A. Elener, MD

Brandywine Family Medicine, 1401 Foulk Rd, Wilmington 19803
Family Practice
Jefferson Medical College of Thomas Jefferson University, Philadelphia, 1987

Frank J. Falco, MD

Ste 4, 4100 Dawnbrook Dr, Wilmington 19804
Phys Med & Rehabilitation (1993)
Temple University School of Medicine, Philadelphia, 1988

T. Ernesto Figueroa, MD

A.I.D.I., 1600 Rockland Rd, Wilmington 19803
Urology
Tulane University School of Medicine, New Orleans, 1983

Neil S. Kalin, MD

Ste 302, 314 Main St
Newark 19711-7181
Ophthalmology (1995)
Emory University School of Medicine, Atlanta, 1990

John J. Kelly, III, MD

Ste 102, 1941 Limestone Rd, Wilmington 19808
Cardiovascular Diseases (1991)
Internal Medicine (1987)
Jefferson Medical College of Thomas Jefferson University, Philadelphia, 1984

Conrad K. King, Jr., MD

1700 Wawaset St, Wilmington 19806 Occupational Medicine
Internal Medicine
University of Pennsylvania School of Medicine, 1978

Kerry Stencler Kirifides, MD

Bldg B, Ste 89,
Omega Dr, Newark 19713
Pediatrics
Hahnemann University School of Medicine, Philadelphia,
1993

Paul C. Kupcha, MD

2501 Silverside Rd
Wilmington 19810-3726
Ste 107, 2600 Summit Bridge Rd, Newark 19702
1941 Limestone Rd
Wilmington 19808
Orthopaedic Surgery
Georgetown University School of Medicine, Washington,
DC, 1986

Mary B. Lansing, MD

Concord Plaza, Naamans Bldg, 3501 Silverside Rd,
Wilmington 19810-4910
Ophthalmology (1992)
George Washington University School of Medicine and
Health Science, DC, 1986

Jacqueline S. Napoletano, MD

Ste 100, 1701 Augustine Cut-Off, Wilmington 19803
40 Polly Drummond Hill Rd,
Newark 19711
Diagnostic Radiology
Temple University School of Medicine, Philadelphia, 1989

Hiep C. Nguyen, MD

Ste 205, MAP, 4745 Ogletown-Stanton Rd., Newark 19713
Thoracic Surgery
Cardiovascular Surgery; General Surgery (1993)
University of Texas Medical School at Galveston,
Galveston, 1985

Leonard A. Nitowski, MD

DFES, PO Box 3048, Wilmington 19804
Emergency Medicine (1986)
Jefferson Medical College of Thomas Jefferson University,
Philadelphia, 1982

John H. Powers, MD

Ste 136, 4745 Ogletown-Stanton Rd, Newark 19713-2070
Infectious Disease
Internal Medicine (1991)
Temple University School of Medicine, Philadelphia, 1988

Maria Carmen Ranola, MD

St Francis Fam Health Center, 312 Lantana Dr, Hockessin
19707 Pediatrics (1993)
College of Medicine, University of the East, Philippines,
1987

Michael Rhodes, MD

Ste 128, 4745 Ogletown-Stanton Rd, Newark 19713
PO Box 1668 MCD, Wilmington 19899, 428-2710
General Surgery (1988)
Surgical Crit Care (1991)
Hahnemann University School of Medicine, Philadelphia,
1970

Corvin V. Robinson, MD

Ste 204, 1400 Peoples Plaza, Newark 19702
Psychiatry
University of Arizona College of Medicine, Tucson, 1989

Harold Rosen, MD

MCD, 501 W. 14th St, Wilmington 19801 428-2962,
428-4934 (fax)
Psychiatry (1976)
Temple University School of Medicine, Philadelphia, 1970

Brian J. Rosenhein, DO

J32 Omega Dr, Newark 19713
Internal Medicine
University of New England, College of Osteopathic
Medicine, Biddeford, ME, 1993

David A. Simpson, MD

1401 Foulk Rd, Wilmington 19803
Family Practice (1995)
Universidad del Noreste, Escuela De Medicina, Tampico,
Tamaulipas, 1987

Anna M. Sullivan, DO

Ste 102, 620 Stanton-Christiana Rd, Newark 19713
Family Practice (1988)
University of Osteopathic Medicine and Health Sciences,
Des Moines, 1985

Judith W. Watson, MD

Ste 403 Kelway Plaza, 314 E Main St, Newark 19711
Obstetrics & Gynecology (1994)
University of Virginia School of Medicine, Charlottesville,
1987

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Christopher M. Meriam, MD

720 S. Queen St, Dover 19904
Orthopaedic Surgery
State Univ of New York-Health Science Center, College of
Medicine, Brooklyn, 1990

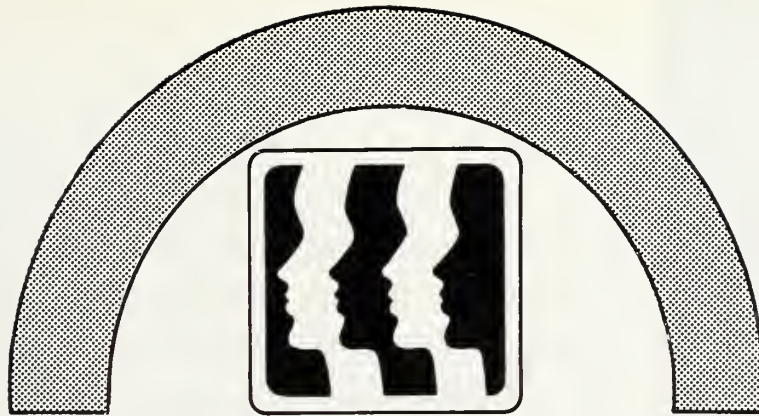
Samuel M. Wilson, MD

807 S. Bradford St
Dover 19904-4137
Vascular Surgery
General Surgery (1985, 1994)
Temple University School of Medicine, Philadelphia, 1979

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MSD MONTHLY ACTIVITIES

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Leadership Activities

- John Kramer MD, interim chair of the Physicians' Health Committee and other committee members began a series of meetings with representatives of the Board of Medical Practice to outline the collaborative relationship between the two entities.
- Carol A. Tavani MD and Mark Meister met with AMA Trustee, Donald T. Lewers MD and Robert A. Doughty MD to discuss a special membership proposal for members of the A.I. duPont Institute medical staff.
- Mr. Meister and James Wilton met with Peter Shanley Esq to discuss the Society's managed care strategy initiative.
- Mr. Meister and Beverly Dieffenbach met with the executive director of the Epilepsy Foundation, Barbara Blair, to discuss changes in the Delaware law regarding reporting of seizure disorders.

Physicians' Advocate Program Activities

- A "Model" contract prepared by the California Medical Association and a legal review of the recent BCBSD amendment was sent out as part of the 1996 Managed Care Contract Review Service.
- *Physicians Advocate* began planning the third annual physician workshop, "Negotiating Skills for the Physician," on September 18, 1996 at the University and Whist Club.

- Provided consulting to three area practices and assisted another physician in starting a solo practice. These consultations included interviewing and hiring initial office staff as well as providing credentialing and start-up preparations.
- Worked with Xact Medicare to update physicians regarding questions raised concerning the Medicare Special Notices dated April 23 and May 28, 1996.

Credentials Verification Organization (CVO)

- Submitted and published article in the DMGMA newsletter regarding Credentialing Connection.
- Initial CVO Steering Committee met on July 17, 1996.
- Renamed CVO to CREDENTIALING CONNECTION Delaware's Professional Verification Service.
-

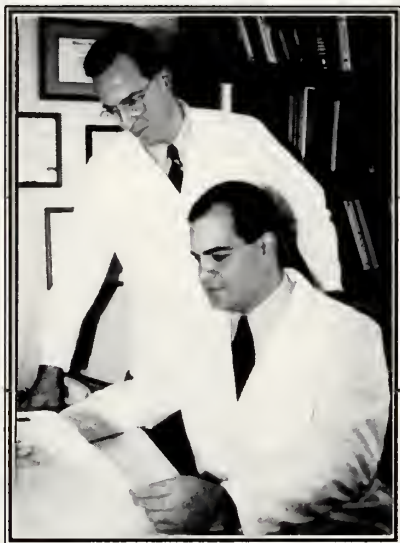
Continuing Medical Education Activities

- Sponsored 10 educational activities for Category 1 credit.

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Health Insurance Market Reforms: We need to expand health insurance coverage by removing current restrictions on pre-existing conditions and end "job-lock" by guaranteeing portability as provided in S. 1028, the Kassebaum-Kennedy bill.

Antitrust Relief for Physician Sponsored Networks: We should promote greater choice and competition through local physician networks by passage of antitrust relief as contained in H.R. 2925.

Patient Protections: Patients need better information and basic fairness safeguards in today's health insurance market. Gag clauses that attempt to restrict physician-patient discussion of treatment options should be prohibited. If mothers and newborns need to stay an extra day, they should be protected from premature hospital discharges.

Medical Liability Reforms: Americans are paying too high a price for the excesses of our legal system. The House of

Representatives passed the California model of balanced medical liability twice last year.

Regulatory Relief: We need to cut red tape by reforming physician office lab requirements and adopting widely supported changes in the so-called "Stark I and II" physician referral laws.

Medicare Reform: Recent reports indicate we are closer to an insolvency of the Medicare program than we previously thought. The Balanced Budget Act of 1995 contained critical reforms that would preserve the Medicare program for current and future generations. We need to enact these reforms while we still have the time.

Medicaid Reforms: Both the Congress and the Administration need to strike a balance between greater state flexibility and assuring continued coverage for our nation's most vulnerable populations.

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The *Delaware Medical Journal* is a monthly publication of the Medical Society of Delaware. The *Journal* reaches approximately 75 percent of the state's physicians, as well as medical libraries, and hospitals; its circulation is approximately 1,640.

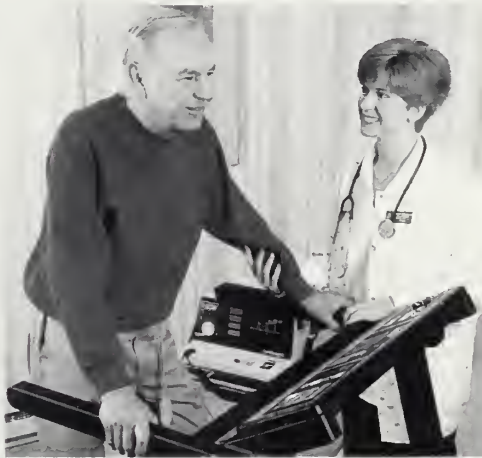
Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting.

Closing for space reservations is the first of the month, two months prior to publication. Closing for materials is the first of the month, one month prior to publication.

All advertisements are subject to approval by the Publications Committee of the Medical Society of Delaware.

For a media kit or for more information, call Heidi Sigmund, assistant editor, at 302/658-7596 or 800/348-6800 (Kent or Sussex Counties).

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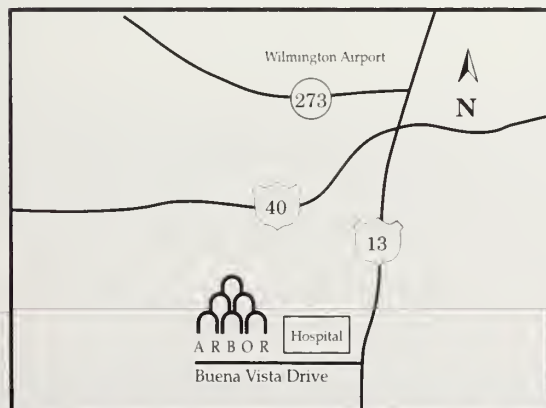
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DELAWARE MEDICAL JOURNAL

Official Publication of the Medical Society of Delaware

VOLUME 68

OCTOBER 1996

NUMBER 10

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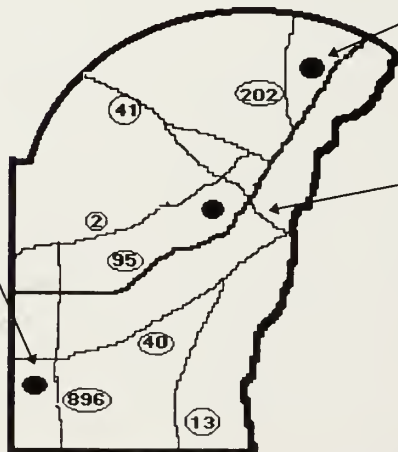
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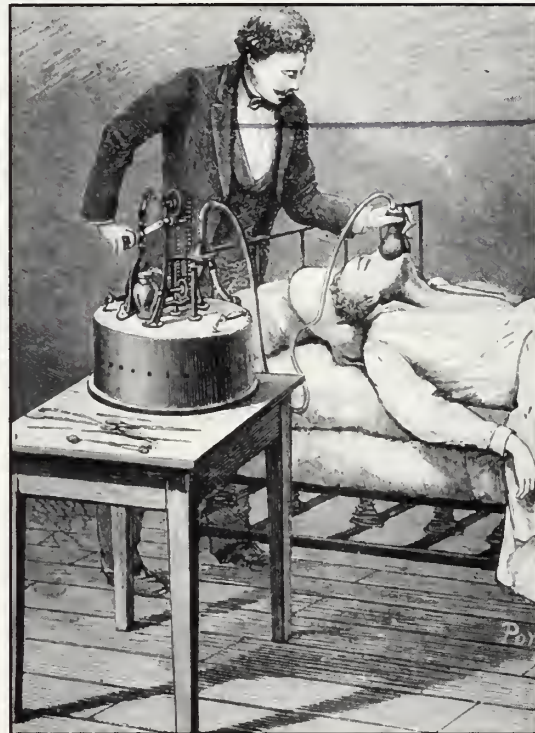
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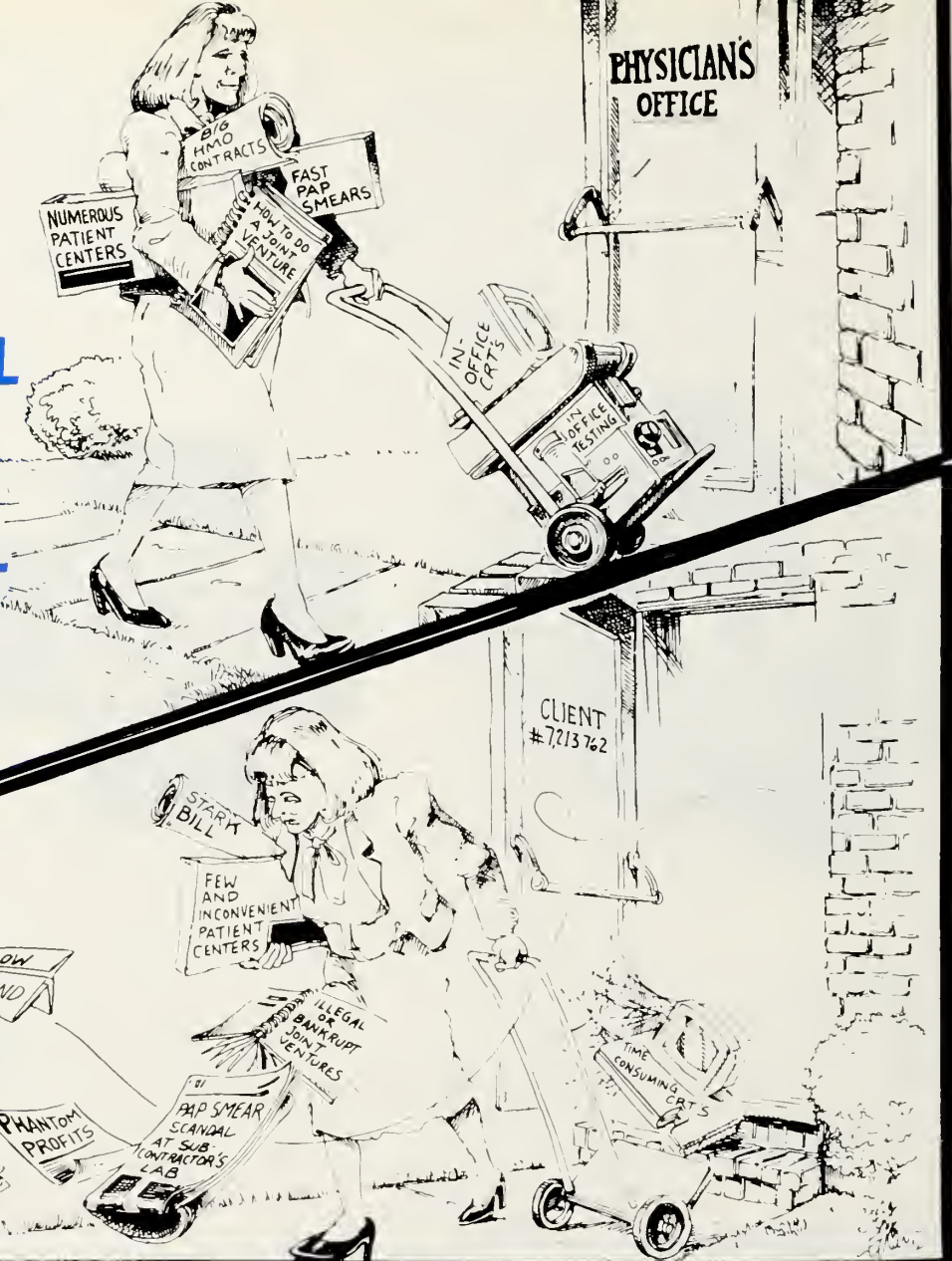
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Relief From Antitrust: Finally in Sight

In 1941, the Supreme Court upheld a criminal conviction of the AMA over what was held to have constituted conspiracy to obstruct the operation of an HMO-type health plan in Washington, D.C. Federal guidelines have so restricted the ability of physicians to form networks as to have made physician organizations all but impossible without running afoul of antitrust laws. Physicians have had to assume substantial financial risk, entering into capitation and withhold arrangements, wherein the amount withheld was large enough to influence practice patterns. Moreover, such arrangements require more capital than most physicians can muster, and skill in managing insurance risk that most physicians lack.

In a rather dramatic revision of these guidelines, the U.S. Department of Justice and the Federal Trade Commission released a new set of guidelines, which remove many existing barriers to network formation. In addition to those mentioned above, there is the additional quandary of whether a capitated system would require an insurance license; many of the state insurance commissioners believe a license is required. It takes considerable capital just to qualify for one.

Another problematic area in the old guidelines were restrictions on the size of physician networks; these limitations made it difficult for a network to compete or to increase competition amongst payors.

The new guidelines go a long way in resolving these problems, by expanding the options open to physicians, enabling them to

develop networks which are feasible as well as competitive in the health care "marketplace." Here are the key features of the new policy:

1. Physician networks may well be legal even though they are not capitated or share financial risk, if the network can show a cooperative effort to control costs and improve quality of care, as for example, if it invests in technology, shares information, and regularly reviews physician performance.

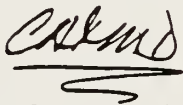
The means by which physicians arrive at fee arrangements with payors without agreeing among themselves what they will charge is now more easily accomplished, via a more efficient messenger model (wherein an intermediary or representative negotiates a fee schedule with the payor on behalf of all the physicians in the network).

2. The new guidelines permit physician joint ventures of the size necessary to be competitive (insurance companies have never had to limit the size of their plans). The FTC and Department of Justice will permit a network to include a large proportion of physicians in a particular market, as long as there exists sufficient divergence of interest and incentive to reduce the likelihood of anticompetitive conduct. In fact, physician networks may encourage, rather than inhibit competition, by providing more alternatives and options to those purchasing and using the services.

3. Physician networks which accept insurance risk through capitation and also offer fee for service arrangements were not formerly allowed to negotiate with the same payors for both products. Under the new guidelines, however, the network can negotiate both types of arrangements, as long as certain criteria such as utilization review programs, used by the network, are applied to both.

These very positive revisions acknowledge changes that have occurred in the health care arena, such as the benefits to patients of physician-designed and governed ventures. They also reflect the accomplishment of major objectives for which the AMA has been persistently advocating. The changes were made subsequent to tremendous support of the introduction of HR 2925, "the Hyde Bill," sponsored by Representative Henry Hyde (R., IL), Chairman of the House Judiciary Committee, with 153 bipartisan cosponsors; the bill sought a "rule of reason" approach to determining the legality of physician joint ventures rather than the old posture that physician joint ventures were illegal per se, and automatically considered anticompetitive.

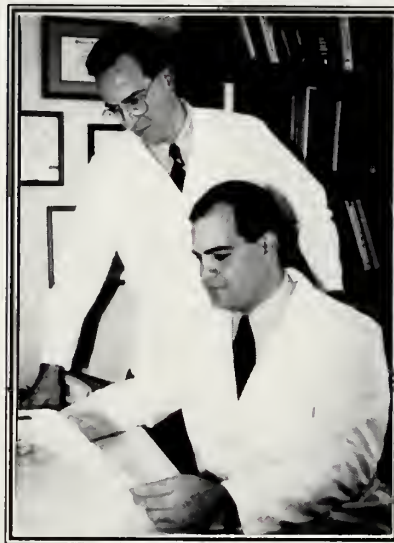
The guidelines ("Statements of Antitrust Enforcement Policy in Health Care") are quite lengthy and complex. Physicians continue, of course, to require legal counsel as they create and structure their networks. The Medical Society may be contacted regarding how to obtain the guidelines. The exciting part is that they have facilitated our ability and opportunity to organize ourselves in such a fashion so as to shape proactively the face of health care in America.



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A Review of the Genetics of Recurrent Pregnancy Loss

Edward A. Trott MD
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Abstract

The field of recurrent pregnancy loss (RPL) has seen a blossoming of investigations in the etiology and treatment of this condition over the last few years. Despite all of this activity, there remains much controversy in all aspects of the field. This ranges from discrepancies in the definition of recurrent pregnancy loss to elements in the work-up and the very existence of certain conditions for which aggressive therapeutic modalities are proposed. We will discuss the genetic component of RPL which is one of the few etiologies for RPL which has achieved near universal acceptance.

Definitions

Abortion, miscarriage and pregnancy loss are a few of the multiple definitions proposed for the clinical presentations associated with recurrent pregnancy loss.

From the onset, one must recognize the various faces of reproductive failure. It is most inappropriate at this time to work-up patients with infertility or biochemical pregnancy losses in the same way as patients with repetitive clinical pregnancy losses.

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Much of the current confusion about terminology stems from a certain recent pursuit for "political correctness." The broad-based debate about elective or therapeutic abortion has created a very negative connotation for the term. Previously used medical terms such as Habitual Aborter or Recurrent Abortion have been misconstrued by the lay public as referring to individuals who elect to undergo numerous voluntary interruptions of pregnancy. In this context, the terms miscarriage, spontaneous abortion, or pregnancy loss have been substituted. The one problem with pregnancy loss is that it is variably used in the context of abortions only, stillbirths only or in the global context of abortions and stillbirths. We prefer to use the term in its global context, as this best reflects the varied clinical presentations of the underlying etiologic factors associated with recurrent pregnancy loss. Any therapeutic intervention should be considered in the specific context of the patient population studied and how this relates to any given patient.

Number of Losses

There is an ongoing debate as to how many losses should trigger a diagnostic work-up. Most of the controversy revolves around two compared to three losses. The other area of debate concerns consecutive and non-consecutive losses.

An increasing number of losses with no liveborn is often misconstrued as a strong indicator of an underlying parental chromosomal problem. Except for the very rare

instance of homologous robertsonian translocation, most balanced parental translocations will yield a mixed history of normal liveborns and pregnancy loss. Therefore, the higher the number of losses, the less likely a parental chromosomal rearrangement will be identified. The same holds true if consecutive losses only are considered.

In summary, it is critical to closely establish the definition of pregnancy loss used to derive data and therapeutic recommendations. Studies which look at two or more losses, regardless of order, will necessarily include more couples with genetic etiologies. The greater the number of losses, particularly consecutive losses, the more likely other factors will be involved.

Genetic

Genetic causes of RPL are overwhelming and there is evidence that genetic factors are responsible for all stages of fetal development failure with high output in most early pregnancy losses.

Any couple with a history of RPL should undergo a thorough genetic investigation. The goals are to identify couples at risk for being carriers of a balanced translocation and individuals at risk for other genetic disorders associated with pregnancy loss. Simpson et al proposed that only couples with a family history of stillbirth or abnormal liveborn should be considered at risk as carriers of a balanced translocation.¹ All couples should therefore be considered for a genetic work-up. The initial step in the evaluation of the couple is to perform a complete pedigree analysis.

Chromosomal Studies

Balanced chromosomal rearrangements in one of the parents is one of the few etiologies for RPL which has achieved near universal acceptance.^{2,3,4} The actual outcome of such pregnancies includes unbalanced abortus, unbalanced liveborn, liveborn balanced translocation carrier and normal liveborn. In most instances, the chromosomes involved in the balanced translocation are the same as those involved in the unbalanced outcomes. In rare cases, the balanced translocation may provoke

nondisjunction of other chromosomes during meiosis, the so-called interchromosomal effect.⁵

The traditional approach to chromosomes studies has been through blood leukocyte karyotyping with G and Q banding. In most cytogenetic laboratories, this will yield between 400 and 800 bands to be studied. Several case reports have suggested additional benefit may be derived through high resolution banding (HRB), with studies of over 1,000 bands.

Families with Rett syndrome are also at risk for RPL and this disorder can also be diagnosed through HRB.⁶ There is still no proper study comparing traditional karyotyping to HRB. The problem with HRB is that it is extremely time consuming and personnel intensive to review the whole karyotype. In most instances, a specific chromosome or areas are targeted for study on HRB karyotype. It is our opinion that standard studies should be used as routine screening tests while HRB studies should be considered in couples where a specific defect is suspected, on the basis of family history or prior abnormal fetus. The same statement also applies to fluorescent insitu hybridization (FISH) studies.⁷

A frequent issue revolves around the need to karyotype both parents when a woman who has had two or more abortions is now attempting pregnancy with a new male partner. There is no data to guide us in this decision. However, the risk of someone in the general population being a balanced translocation carrier is estimated to be 0.2-0.1 percent.⁸ Because of the impact of the finding of an abnormal karyotype, we prefer to perform the study on both partners rather than reassure the couple based on the findings in the female patient, and at a later time to find the male to be a translocation carrier. There have been rare cases where both partners have been found to be translocation carriers.⁹

Standard karyotyping can be performed on abortuses. The yield of cultures varies greatly based on the quality of the material, the time between demise and collection of the sample and the risk of maternal contamination. Some have advocated performing chori-

onic villus sampling (CVS) to obtain the material for study. Other techniques which have been used to study the karyotype of abortuses include direct preparation from CVS material^{10,11} and flow cytometry.¹² A recent report documents performing FISH on paraffin-embedded abortion material, offering new vistas for these studies.¹³ The standard at present continues to be standard karyotyping. Any abortus or stillbirth should also be studied through a formal autopsy.¹⁴

In summary, a chromosome analysis using banding techniques and an adequate chromosome count should be performed on all couples having a history of RPL or with a pedigree showing one abortion plus one malformed fetus. Abnormal findings include parental balanced translocations, pericentric and paracentric inversions, or X chromosome mosaicism. In addition, whenever possible, karyotyping of an abortus, stillbirths or abnormal liveborn should be performed. The detection of any cytogenetic abnormality is extremely important for appropriate counseling and the tailoring of an appropriate plan for prenatal cytogenetic monitoring.

It has been proposed that cytogenetic studies of the parents have become superfluous. We take exception to that position. Many couples who are translocation carriers will elect not to pursue further attempts at pregnancy or opt for donor gametes. It is therefore critical to provide couples with as much information as possible. Most often, this will include parental karyotypes.

Other Genetic Conditions

There are relatively few mendelian genetic disorders which have been linked to RPL. Most of these can be identified through an appropriate family history. Many ethnic groups are at increased risk for alpha thalassemia, a lethal condition in the homozygous state, which manifests as fetal hydrops and intrauterine death.¹⁵ Other genetic disorders linked to RPL include certain forms of Gaucher's disease.

It is important to recognize pedigrees where all liveborns are females, half of whom are affected by the disorder, and all losses are

males. These X-linked disorders associated with hemizygous male abortuses suggest the effect of a single gene mutation in what otherwise would be euploidic abortion. Rett syndrome, focal dermal hypoplasia, incontinentia pigmenti, oral-facial-digital I syndrome are among such disorders.^{6,16}

Multi-factorial disorders, including neural tube defects may also play a role in RPL.^{17,18} Once again, the pedigree information can be of great assistance. These disorders are more difficult to diagnose at present. Targeted ultrasound scanning and counseling are often the only tools available.

The diagnosis of these genetic disorders can be accomplished through cytogenetic studies, HRB studies, FISH or other DNA diagnostic studies.^{19,6,20,13}

The Case for a Work-Up After Two Losses

It is prudent to initiate a work-up after two losses, regardless of the order of these losses. There is no evidence from several reported series that increasing the number of losses to three or more leads to any change in the yield of chromosomal rearrangements detected.^{2,3} The argument that a work-up after two losses only will have too low a diagnostic yield is therefore not supported.

The second important consideration has recently been emphasized by a study by Drugan et al.²¹ They prospectively studied 305 young couples with a history of two or more unkaryotyped abortions and normal parental karyotypes. There were five cases (1.6 percent) of aneuploidy diagnosed at amniocentesis or at birth in this population. By contrast, only three aneuploidic conceptions were detected among 979 (0.3 percent) controls. This prevalence of aneuploidy in conceptions from couples with two or more losses is in line with the data tabulated by Hook et al.²²

On the basis of this data, we feel it is important to discuss prenatal diagnosis in any couple who has suffered two losses or more, regardless of the order of the losses. This data must be enhanced with more studies. It must also be emphasized that these estimates apply to couples with an otherwise negative work-up.

Conclusion

This field of medicine continues to evolve rapidly. Along with these developments, diagnostic modalities evolve and progress. This is an exciting time. The astute clinician will keep abreast of the developments but will also view them with appropriate circumspection.

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Hypothermia Accompanied by NonCardiogenic Pulmonary Edema: A Case Report

Dean Otto MD

Mark Franke MD

John F. Madden MD FACEP

Introduction

Presented here is a case of a young male found unconscious due to the combined effects of an opiate drug overdose and hypothermia. A brief discussion on the treatment of this patient follows.

Case Presentation

A police officer stopped to check an auto parked in an unusual place and found three apparently intoxicated individuals seated in the car. A fourth person in the car was unresponsive. An ambulance was immediately summoned and the patient transported to the Emergency Department.

Upon arrival, the patient was found to have a respiratory rate of 5 per minute, a BP of 86/40, heart rate of 105 and a rectal temperature of 29° C (84.2° F). The pupils were noted to be pinpoint, and the patient responded only to painful stimuli. The patient's ventilation was assisted with 100 percent oxygen via bag-valve mask, an IV was started with warmed normal saline and 2 mg. of Naloxone (Narcan) was given IV. The patient quickly became combative with resolution of his pinpoint pupils and bradypnea. The pa-

tient became more combative and required restraints. Physical exam was unremarkable except for a tachycardia and bilateral rhonchi. The patient soon became dyspneic and tachypneic and developed crackles throughout both lung fields. An arterial blood gas on 100 percent oxygen via face mask revealed respiratory acidosis and hypoxia (pH 7.09, PCO₂ 52, HCO₃ 16, PO₂ 47, O₂ saturation 66 percent). The patient was promptly intubated using rapid sequence intubation (RSI). The ECG revealed sinus tachycardia at 125 per minute with no acute changes (Figure 1). Chest x-ray (Figure 2) revealed a normal sized heart with florid pulmonary edema. Laboratory results were significant for a Na of 151, K of 6.2, non-fasting glucose of 282, an Anion gap of 24, a wbc of 21.8 with a shift to the left, an Hb of 13.4 and an Hct of 41.5 percent. A urine toxicology screen was positive for cocaine and opiates. The blood alcohol test was negative.

The patient was treated with heated oxygen via the ventilator, warmed IV fluids, heated blankets and warm bladder and stomach irrigation. His rectal temperature reached 37° C within four hours of arrival in the ED with these conservative warming measures. He was admitted to the ICU with a diagnosis of hypothermia, non-cardiogenic pulmonary edema and cocaine and opiate overdose. A Swan-Ganz catheter and an arterial line were placed for hemodynamic monitoring. Due to continuing hypercarbia and hypoxia, PEEP was gradually increased to 13. A follow-up CXR on hospital day number two revealed a left apical pneumothorax. A left thoracostomy tube was placed with relief of the pneumothorax. On hospital day four the patient's hypoxia had improved and he was

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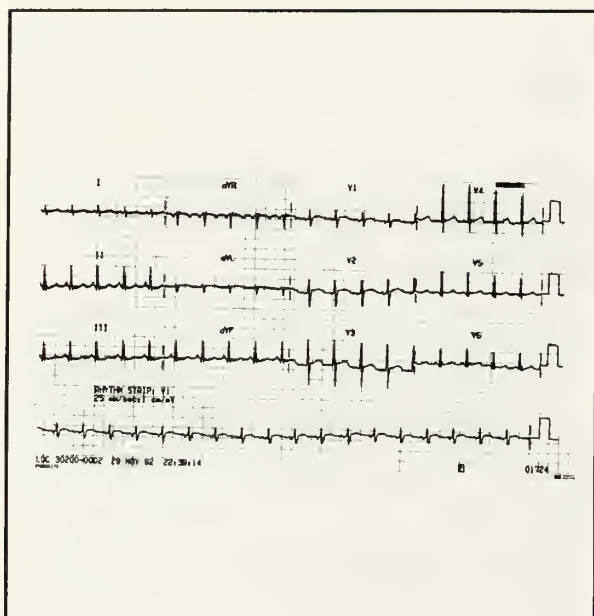


Figure 1. Electrocardiogram of hypothermic patient showing tachycardia

weaned from 100 percent oxygen and PEEP. On hospital day number seven, the patient was extubated. Multiple blood, urine and sputum cultures were negative during the hospital stay. The patient responded to treatment and after physical rehabilitation due to deconditioning, was discharged after 12 hospital days.

Hypothermia

Hypothermia is commonly defined as a temperature below 35° C (95° F). Although more frequent in cold climates, it can occur in any season and in warm climates. It has been occurring with increasing frequency¹ and moderate to severe cases require urgent and aggressive therapy. In severe cases, marked depression of neurologic and cardiovascular function can simulate death.

There are two classes of hypothermia. Accidental or primary hypothermia results from exposure to an environment which is cold relative to body temperature. This can be further divided into immersion and non-immersion exposure.² Secondary hypothermia results from a failure of thermostasis by the hypothalamus; causes include sepsis, shock, drugs, metabolic disorders, trauma and skin disorders. Hypothermia occurs more frequently in compromised individuals - ex-



Figure 2. Chest x-ray of patient showing acute pulmonary edema. Note the normal heart size on this A-P view film.

tremes of age, medically ill, and intoxicated individuals - those who cannot or choose not to alter their environment.

Mild hypothermia is defined as temperatures between 32° and 35° C and present as an excitation or responsive stage. Clinical features include shivering and mild increases in heart rate and blood pressure. Motor dyscoordination and mild clouding of consciousness are observed. Temperatures between 30° and 32° C are classified as moderate hypothermia which presents as an adynamic stage, with a decline in metabolic rate and physiologic functions. Clinical hallmarks include lack of shivering, bradycardia, diminished pulses, and lethargy. Respiratory depression leads to hypoventilation, while negative inotropic and chronotropic effects lead to hypoperfusion.

Severe hypothermia, below 30° C, is characterized by unconsciousness, muscle rigidity, severely depressed respirations, and malignant arrhythmias. Bradycardia often progresses to atrial fibrillation with a slow ventricular response, but ventricular arrhythmias, including ventricular fibrillation can be seen. Ventricular fibrillation can be induced upon handling the patient, and this can be refractory to standard therapy - including defibrillation and medications - below

28° C. Declining temperatures below 27° C can result in the loss of deep tendon reflexes, pupillary reflexes, and even cardiac standstill. A patient in this state, without apparent signs of life but severely hypothermic, presents a management dilemma shrouded in controversy. As outlined by ACLS, treatment includes CPR, active rewarming of the patient, and treating VF with defibrillation at 200, 300 and 360 joules. Use of medications is controversial, with many authors recommending withholding drugs until core temperature of 30° C is achieved,¹ while others recommend dosing at half the normothermic dose to compensate for impaired drug clearance.

In addition to cardiac depression and arrhythmias, complications may be severe. Pulmonary effects include respiratory depression, diminished or absent cough and gag reflexes and bronchorrhea posing a high risk of aspiration. In addition to hypoventilatory changes, blood gases show a mixed acidosis from hypoperfusion. The concentrating ability of the kidney is impaired, leading to a "cold diuresis" and hypovolemia. Additional complications include pancreatitis, disseminated intravascular coagulation, and impaired hepatic function as evidenced by impaired metabolism

of medications such as lidocaine.

Management includes prompt recognition of hypothermia and an accurate measurement of core temperature by an esophageal or rectal probe. These patients require prompt removal from their environment including removing all wet clothing, drying their skin, and covering with blankets. Care must be taken in moving patients to prevent ventricular fibrillation, while pulselessness and apnea must be observed for 45 seconds or more before arrest is confirmed. Anyone with a temperature below 32° C should be placed on warmed, humidified oxygen and warmed normal saline infusion. Those patients with cardiopulmonary arrest or shock can be aggressively warmed by saline lavage of stomach, bladder, peritoneum, or pleura, as well as hemodialysis or cardiopulmonary bypass.

Significant hypothermia is a life-threatening emergency requiring rapid recognition and response. Case reports of complete, neurological recovery after one hour submerged in icy water are uncommon, but well documented.^{2,3}

Noncardiogenic

Pulmonary Edema (NCPE)

This case clearly demonstrates one of the potentially lethal sequelae of heroin overdose, noncardiogenic pulmonary edema, which in the past has also been referred to as "heroin lung." Heroin and related narcotics can cause multiple harmful effects on the respiratory system, including acute hypercapnia, hypoxemic respiratory failure, decreased vital capacity, increased A-a gradient, V-Q mismatch, lung perfusion defects and NCPE.⁵ In its most severe form NCPE lies on the spectrum of ARDS.⁶ Noncardiogenic pulmonary edema has multiple etiologies (Table 1) and its pathogenesis is poorly understood.^{7,8}

Noncardiogenic pulmonary edema was first described by William Osler in 1880 in a case of narcotic poisoning. In describing the lung, "I have never seen an organ so infiltrated with bloody serum."⁹ Although seen commonly with heroin, NCPE has been associated with other narcotics including morphine, methadone and dextropropoxyphene.^{9,12} The onset of symptoms of pulmonary edema may be instantaneous, but usually occur within two hours of injection. With oral ingestion symptom onset can be delayed further.¹⁰ Clinical signs and symptoms vary somewhat

Table 1

Alterations in

Pulmonary Capillary Permeability

- A. Shock
- B. Infection
- C. Drug-related (Heroin, Salicylates)
- D. Inhalation injury
- E. Hematologic disorders
- F. Immunologic disorders
- G. Metabolic (Pancreatitis)
- H. Multiple trauma

Miscellaneous and

Poorly Understood Causes

- A. High-altitude pulmonary edema
- B. Uremia
- C. Neurogenic pulmonary edema
- D. Eclampsia
- E. Re-expansion of unilateral pneumothorax

but include; apnea, tachypnea, hypoxemia, cyanosis, hypotension and frothy sputum at the mouth. Rales may be present bilaterally, unilaterally or may be absent.^{10,12} Chest x-ray findings typically demonstrate a bilateral alveolar infiltrate pattern. Treatment primarily consists of respiratory support and oxygenation. Endotracheal intubation and mechanical ventilation with the addition of PEEP may be necessary to maintain adequate ventilation and oxygenation.⁵ Naloxone should be given for the treatment of respiratory and central nervous system depression. The use of diuretics, digitalis and morphine is not recommended and indeed, may be harmful.⁸ Clinical findings usually clear in 24-48 hours while radiographic findings may take several days to resolve. Radiographic findings that persist should be considered suspicious for aspiration pneumonia.¹² Mortality rates vary widely.

The exact pathogenesis of non-cardiogenic pulmonary edema in heroin overdoses is poorly understood. However, many mechanisms have been proposed in the past, including; hypersensitivity reaction, toxic reaction to impurities in heroin, neurogenic reaction and hypoxia.^{10,11,13,14} The most plausible explanation appears to be that hypoxia causes severe pulmonary vasoconstriction which in turn causes capillary damage and leakage resulting in pulmonary edema.^{11,12,13}

Summary

The combination of severe hypothermia and noncardiogenic pulmonary edema secondary

to an opiate overdose is presented. This case emphasizes the importance of ventilatory support and rewarming techniques available in the emergency department setting.

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Seventeen Percent Wrong: An Introduction

Acute appendicitis can be at times the easiest of diagnoses, but at other times the most difficult. Just when you think you know it pretty well, it shows up in a new disguise. We all learn to recognize diseases by patterns: — the squeezing retrosternal pain and vomiting of the myocardial infarct; the warm, tender, symmetrical synovitis of rheumatoid arthritis; the shaking chill and purulent or rusty sputum of pneumococcal pneumonia, etc. I recently got a new insight into the pattern of appendicitis from a fine Seaford surgeon when he said (essentially) "The pattern of appendicitis is its evolution over time." In other words it is not the location or any characteristic of the pain or the association of diarrhea or vomiting or fever or physical findings - all of which may or may not be present at any given time, but how the picture evolves over time. I think that is worth knowing. Why did none of my many teachers ever tell me that critical bit of information before? It follows logically from that, never send a patient with abdominal pain home without firm arrangements for follow-up by yourself or others for 24-48 hours or until all symptoms have cleared. If all you have is a snapshot instead of a moving picture, you'll miss it. As I think back over 50 years, of the doctors I've seen get into trouble over appendicitis, it is nearly always for lack of follow through plus a high index of suspicion. Inevitably many normal appendices are removed. They should be! I am told the correct proportion is 17 percent. If it is less than that your suspi-

cions are not high enough and you are in danger of missing some hot ones. I wonder if the managed care nurses who decide who gets admitted or operated know that.

Recently I had an unusual experience, an opportunity to talk with a surgeon who was on the faculty of my medical school when I was a student there 50-55 years ago. He is not only still alive, but sharp and clear, though he must be in his 90s. The only thing I might fault him for is bad judgement, as he was trying to get a Delaware license so he could start charging for the advice he recently has been giving away free. He is still a fine doctor, and was able to recall some very interesting cases of appendicitis — which he wrote up and sent me for publication. His article follows.

E. Wayne Martz MD

Appendicitis and The Surgeon's Bread and Butter

Charles Schnee MD

During the latter years of the 19th century and the early years of the 20th, appendectomy came to be known as "the surgeon's bread and butter," a derogatory reference to the \$50 or \$70 fee a person paid for being saved from peritonitis.

In those years the terms asepsis and antisepsis were still not fully understood or religiously accepted. It was also a period when the mention of hospital, or surgery to an elderly patient, meant death. I can testify to many such encounters. This ingrained mental conviction went back a hundred years or more to a time when pregnant women in Vienna chose to have their babies in the street rather than in the obstetrical ward of the "Algemeines Krankenhaus" where puerperal fever was rampant and nearly always followed by death.

Let us consider the 19th and 20th centuries. They were eras during which biological sciences opened a new world in medicine and surgery. In the short space of 100 years, scientific geniuses such as Semmelweis, Pasteur, Koch, Virchow, Chamberlain, Joseph Lister and Oliver W. Holmes, all men of honor and discovery, worked during their lifetimes against slander and defamation.

No, I have not forgotten the "bread and butter surgeon" or appendicitis, still the most common abdominal disease. Today it is listed under many different pathological findings, but it can masquerade under other lower abdominal entities as well.

So that one dare not point a finger at the early misjudged surgeon or the family doctor who met opposition with the mention of operation; when rebuffed he ordered bed rest, fluid diet, mild sedative for pain and the misleading ice bag to the RLQ. Sometimes the pain subsided with disastrous consequences of a ruptured appendix and peritonitis. Treat-

ment was Penrose drainage resulting in death or long hospitalization, and if fortunate, recovery. (I know I was there.)

I present, with your permission and consideration, several truly amazing appendiceal entities that I encountered simply by having a "take a look" approach to some cases of occult abdominal pain.

In 1954 I joined a clinic in North Dakota and became a surgeon to two small local hospitals. My new partners had my first case ready. The patient was a man in his second admission with the same complaint. He had all the cardinal signs of appendicitis. Surprise, he had been operated upon by one of my partners on his first admission. The operative note indicated no appendix or other pathology. The incision was closed and he was sent home.

It was now my turn. Incision; yes, there was no appendix, but with all the signs and a high WBC, it must be somewhere. Retracting the colon medially, there in the retroperitoneal space was a bead of pus coming through the peritoneum just below the liver. The appendix was removed, peritoneum left open, and drained.

Next case, a 10 to 12-year-old girl. Mother stated the child complained of RLQ discomfort; no nausea or vomiting, normal bowel function, no fever; yes, there was slight discomfort on palpation in RLQ, normal temperature and WBC. After some explaining and mother's consent, I was able to do a rectal; negative, stool on glove normal. Appendectomy I felt would make me a candidate for the bread and butter league, but I explained to the parents that I could take a look through a small incision. I got their signed consent.

Through a McBurney, the appendix was removed. Guilty, I had removed a normal organ,

except it did appear a bit swollen. Surprise, on post-operative incision the appendix was stuffed with ascaris lumbricoides. Appendicitis is reported to be unusual in this type of parasitic infestation.

A third case was indeed an oddity. The patient was a young man who complained of a dubious feeling in his right lower abdomen. He was not ill enough to stop work and came for examination and an opinion. History and complaints were abbreviated and not those of appendicitis. On examination, there was a questionable RLQ tenderness, and discomfort on rectal, WBC normal. The case suggested some possible pathology, but not appendicitis. The incision revealed the appendix to be the size of a small sausage and coal black, but not ruptured as one sees in gangrene due to infection. This pathology was due to vascular loss; thrombosis of the ileoappendicial artery.

A fourth case was a thirty-year-old male. Complaint, discomfort in RLQ and a feeling of fullness. He then stated he had seen two physicians prior to seeking the opinion of our clinic. Both surgeons after examination, rectal and WBC etc. told him there was no evidence of appendicitis and discharged him. On my examination in all honesty, I could only agree with the two previous physicians. Nevertheless, one could not disregard the patient's making three attempts to confirm his own opinion that something was not right in his right lower quadrant. With the patient's consent and through a McBurney incision, we took a look. It was like hitting the jackpot at Las Vegas. The appendix was a cystic mass slightly smaller than a golf ball. A mucocele was removed, being careful not to spill the contents (which gives rise to pseudomyxoma peritonei, which can be fatal.)

The next case was that of a young boy with all the signs of an acute RLQ or mid-abdominal pathology - abdomen tender to spastic, rectal positive, WBC elevated and urine negative. My opinion was an acute appendicitis or other undiagnosed mid-abdominal infection. Exploration through lateral rectus incision. Diagnosis, Meckel's diverticulum removed avoiding spillage, and appropriate ileum closure.

Our next unusual case illustrates something else masquerading as appendicitis. On exploration, appendix normal, but ileum loosely matted medially. Separating the ileum, suddenly there was a sharp stick

through my glove and into my index finger. I withdrew for obvious reasons, took care of the wound, rescrubbed, returned and cautioned my assistant to carefully explore. Shortly he found the sharp point piercing the gut. It was that thin sharp pointed bone next to the humerus of a chicken. We closed the perforation and put in Penrose drains. The patient and I both recovered.

The following case is one that could only be found in the dark ages of medicine and surgery. The patient was referred to me by a very capable physician who was called as a consultant by the family of this very young girl. In short, it was a clear case of ignorance and the body's natural immunity to isolate and cast off an infection. Without detail it was a clear history of appendicitis with a large abscess pointing through the abdominal wall. With incision, suction drainage and Penrose drains, with the help of the body's natural defenses the child recovered. There were no antibiotics.

Very briefly, there was one case of appendiceal obstruction due to shotgun pellets. The hunter enjoyed his game at mealtime, as well as in the field.

The last case was beyond doubt one of acute appendicitis. I advised immediate surgery. In no uncertain terms the patient said that I was wrong and that he was prepared to go on a two week vacation. And he did! About ten days later, a neighboring physician called me at the hospital to say he had seen the recalcitrant patient and diagnosed peritonitis. The patient arrived at the hospital and we operated immediately; no exploration, just drainage of both sides of the abdomen. Six weeks at St. Vincent's Hospital. There were no antibiotics, just devoted care. His appreciation? We were all treated as malefactors of his survival. Such, in the lifetime of a physician, are the unpredictable vagaries of medicine.

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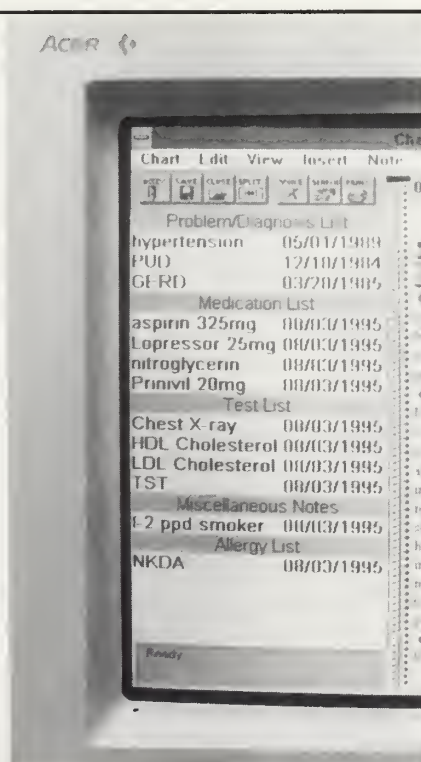
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Managing Managed Care

James H. Wilton

As a medical society executive recently stated, "In today's marketplace you either make it happen, watch it happen, or wonder what happened." This summer the Board of Trustees took the step to make it happen. How? By developing the means of assisting Delaware physicians to enhance the quality and efficiency of medical care, contain costs, maintain clinical autonomy and oversee revenue distribution. The means of accomplishing this Herculean feat is a new subsidiary called Medical Network Management Services of Delaware, Inc. or MED-NET OF DELAWARE, for short.

MED-NET OF DELAWARE is a wholly owned subsidiary of the Medical Society. That means there is no one to whom this company responds or owes allegiance except physicians. It is a service company designed to meet specific needs of local community physicians striving to maintain a quality medical practice in an ever-changing health care delivery landscape. Most specifically, it is designed to aid in the relationship with the GIANT, managed care; but not by conquering it. Rather, once a network of local physicians has been properly organized and equipped, MED-NET OF DELAWARE will assist physician organizations (POs) to work with hospitals, contract with managed care companies and effectively utilize medical resources and manage risk.

Mr. Wilton is the Chief Executive Officer of Medical Network Management Services of Delaware, Inc. or MED-NET OF DELAWARE. MED-NET is the Medical Society's newest wholly owned subsidiary.

MED-NET OF DELAWARE will assist these networks to obtain the optimum managed care contracts, properly align incentives, and facilitate each integral component of the health care delivery system to do what each does best. Through proper organizational structure, appropriate strategic relationships and thorough, careful education, we believe the quality of health care can be enhanced, overall cost contained and fair compensation returned to those who render the services.

What does this mean for Delaware physicians? It means they are going to have to make a choice! As Dr. Jim Reinertsen, MD, former president and chief executive officer of the Park Nicollet Medical Center, a 370-physician multispecialty group practice, recently stated, "If we aren't leading, then we're going to do the bidding of the managed-care companies." What both the managed care companies (MCOs) and the hospitals have realized is that the key to their success is not one of them. Guess which of the players in the medical care delivery arena it might be? If the answer was PHYSICIANS, that is correct. The real question is, what are Delaware physicians going to do with the knowledge?

As we traveled throughout this state last spring, meeting with over 70 people about their feelings regarding managed care, the one thing we heard from physicians over and over and over again was that this is a scary time. There is a tremendous uncertainty and the landscape changes almost every day. The fear is understandable. It is an ever-changing

market. St. Francis' parent merges with Catholic Health Corp. and Sisters of Charity. Aetna merges with U.S. Healthcare. Delaware Blues merge with New Jersey Blues who merge with Anthem. Kent General merges with Milford Hospital. There is fear of the unknown. There is fear of change. There is fear of an inability to negotiate on a level field or to deal fairly with giants. There is fear of information systems. There is fear of giving up referral patterns, losing autonomy, losing your patient base, losing your revenue, losing your practice. These are all understandable.

Right now the playing field is not level. Physicians all realize that. What MED-NET OF DELAWARE wants to do is to help level the playing field on one hand and improve the efficiency of medical care delivery on the other. This is commonly called quality. The means to that end is the proper alignment of responsibility and authority for those who are in a position to influence the quality of medical care. How we see this happening is through enabling physicians once again to be active voices in the decision-making process of medical care delivery.

What are the steps to accomplish this? First, is the necessity of helping physicians to organize. Right now there is a jumbled mass of individuals or small groups each trying to vie for position and make it on their own. The key to success in the coming market is collaboration, team play and cooperation. The place to begin is physician to physician. Physicians must be willing to come together, be given the authority for and be willing to take the responsibility for the medical care component of health care delivery. This is best accomplished through a model that MED-NET OF DELAWARE assists physician groups to construct. These models are and must be physician owned, physician led and physician controlled. These organizations become the centerpiece of the strategy. They are designed to put the authority and responsibility for the necessary component parts of medical care delivery into the hands of physicians.

Second, is development of the skills and abilities needed for success in the organization. These are the specific capabilities physi-

cians need to effectively negotiate for and manage risk.

Third, is development of strategic business alliances between these physician organizations and other organizations that are key players in the health care delivery market. These alliances are developed and targeted to accomplish the purpose of quality health care. They will include alliances with hospitals, insurers, employers, and others. We want physicians to be positioned to be meaningful and competent components in this environment as it is evolving. Whether that happens is up to the physicians of Delaware.

MED-NET OF DELAWARE is positioned and ready to furnish Delaware physicians all the tools they need to succeed. Physicians must deliver the heart and courage to take the next step. It will not be easy. It will be worth it. It concerns the future of the profession, the relationship to patients, and the ability to imput into the changes occurring in the medical care delivery system. One thing is certain. If Delaware physicians choose not to be involved and the worst happens, they have no one to blame but themselves, for they decided to be passive in this process. There is great risk in doing nothing. They may easily become a contracted service provider in a big corporate amalgamation of Wall Street tycoons or Uncle Sam's universal delivery system. Delaware physicians must decide whether they want to be a player or a pawn. MED-NET OF DELAWARE is here to help you become players.

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Stephen R. Permut MD, JD

Steve Permut, long time leader of our medical community, holder of two doctoral degrees, certified by two specialty boards (Internal Medicine and Family Practice) will be moving his center of operations from St. Francis Hospital, where he has been Vice President of Medical Affairs, to Temple University College of Medicine, where he will become Professor and Chairman of the Department of Family Medicine on October 1, 1996. Steve has been Temple's Acting Chairman of Family Medicine since May, 1996. He will continue to reside in Wilmington and expects to continue some of his key activities with the Medical Society of Delaware.

Steve, we are very proud of your achievements and wish you continued success in your new academic position. We shall miss your daily presence in Wilmington, but recognize this as advancing your career, and rejoice for you.

— E. Wayne Martz MD

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CME

E. Wayne Martz MD

One of the most difficult tasks for the practicing physician to do correctly, is to keep up with medical progress. It is difficult because it is the easiest to let slide. It doesn't push you like the sick people under your care who need answers immediately. It doesn't push you like all the little government bureaucracies, each of which thinks it should be #1 in your life - or you go to jail. It doesn't push you like the office problems - reports, records, billing etc. You don't even need to think about it for days and weeks on end, until suddenly one day you wake up to find you are hopelessly out of date in some important matters.

In Delaware we have long had the general philosophy that this is the way your Continuing Medical Education (CME) should be - unobtrusive. The Category I conferences are always available if you choose to participate in them. Yet you would be amazed at the number of doctors who are scrambling around as licensure renewal time approaches, trying to figure out how they are going to get that paltry 20 or 40 credits they need.

The availability of Category I accredited programs has been assured since 1970 through Jefferson Medical College and the DIMER program. Since 1990 when the Medical Society of Delaware was certified as an accrediting organization, we have pretty much used Jefferson as a fall-back position, available if needed. Most of the Category I programs in Delaware have been accredited through the Medical Society. The Alfred I. DuPont Institute is the only other authorized

accrediting agency in the state. Some of the educational programs at the Medical Center are still accredited through Jefferson, and some individual hospitals have special arrangements with out-of-state accrediting universities, but all of those long-distance accrediting arrangements are under ACCME investigation, and are of dubious stability in terms of long term survival.

The Medical Society of Delaware recently underwent a review by ACCME, and their authorization to accredit Category I programs was extended by four years - the maximum. However, it got pretty scary as they got down to questioning the minutia of our operation, and without Dr. Virginia Collier, who represented us, the outcome would have been in doubt. It should be noted that Peter Mette, the work horse of our Education Committee, died abruptly in March 1996. It should also be noted that university types from large states have difficulty relating to the problems of running CME in a little place like Delaware.

If you add to this the fact that the Governor's Health Care Commission is considering other uses for DIMER FUNDS - such as subsidizing Advance Practice Nurse programs at the University of Delaware - you might get the idea that the accreditation of our Category I programs is skating on very thin ice. I would say your idea is right on target. We need a good, secure fall-back position, as it is written into our laws that Category I credit is required for re-licensure, and that comes up next June 30th and every two years after that.

At this juncture a possible fall-back position has come to my attention. It is a production of the Massachusetts Medical Society, as erudite and forward-looking an organization as one could ask for. Perhaps you have heard of their state medical journal. It is called the *New England Journal of Medicine*. They also have a bi-monthly seven page summary of current medical literature (*Journal Watch*) that I have relied on for years to keep me aware of what is going on.

They now offer an exam twice a year based on *Journal Watch* summaries. A passing grade is worth 25 Category I CME credits, 50 credits per year. I contacted them to see if they will consider giving Delaware a quantity discount. They will if we do all the work - 10 percent off their regular price if we get at least 25 new orders, 15 percent off for 50, etc. If you are interested, call my office at 658-7596. We may solve this problem yet!



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AZT Is Helping Mothers and Their Babies

Eighteen children born since July 1994 to HIV-infected mothers in Delaware will grow up HIV-free, thanks to zidovudine, better known as AZT or ZVD. These healthy children represent a 90 percent rate of success and a triumph for perinatal AZT treatment in stopping transmission from mother to baby.

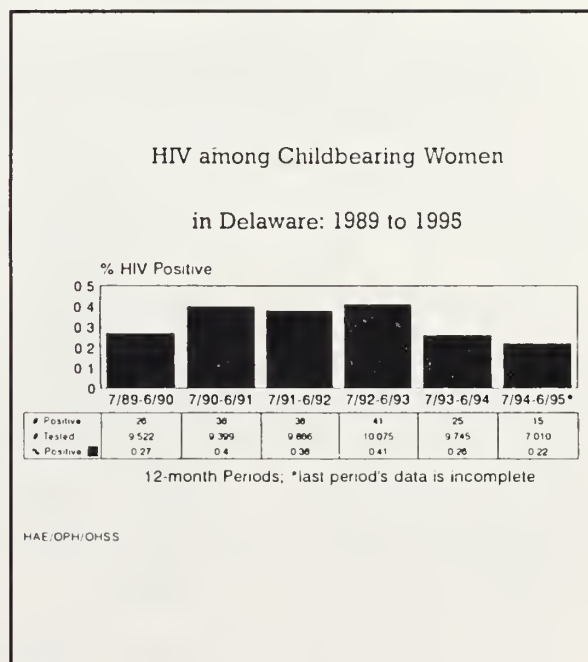
"These figures clearly indicate the importance of offering counseling and HIV testing to *all* pregnant women," says Kathleen Lowthert, Nurse Practitioner with the Community Program of the Medical Center of Delaware. "If the woman tests positive she can then make an informed decision about taking AZT for her baby's benefit and her own."

Only one prospective mother declined to access the therapy at the Medical Center of Delaware Obstetrical Clinic for high risk women.

076 Protocol

A drug research study titled 076 Protocol used AZT to treat HIV-infected women during pregnancy as well as their babies for a short time after birth. The results of the study were so conclusive that in 1994, the Centers for Disease Control and Prevention recommended

that health care providers nationwide make AZT available to all HIV-infected pregnant women and their newborns. This treatment has been shown to successfully reduce, to as low as 8 percent, transmission of HIV from mother to child. Without AZT treatment, 20-30 percent of HIV-positive mothers transmit the disease to their babies. (Details of the treatment guidelines appeared in the *Morbid-*



**Ranking of Top Ten States
by Rate per 100,000 Population
May 1995 through April 1996
Overall U.S. Rate=26.3**

1.	Washington, DC	173.9	6.	Connecticut	43.5
2.	New York	68.9	7.	Delaware	41.7
3.	Florida	55.3	8.	California	34.4
4.	New Jersey	52.5	9.	Georgia	32.8
5.	Maryland	44.3	10.	Louisiana	29.9

ity and Mortality Weekly Report (MMWR),
August 5, 1994, Vol 43, No. RR-11.

HIV Survey Results Among Childbearing Women in Delaware

Assessment of the extent of HIV infection among women who gave birth in Delaware began in 1989. Delaware was one of 46 states participating in the nationwide blinded survey using excess blood taken for newborn metabolic screening tests. Results from several of the twelve-month study periods were published in December 1994. (HIV Seroprevalence Surveys in Delaware: 1989-1993; *HIV/AIDS Epidemiology*, Division of Public Health., This study was suspended in 1995.

The figure (to the right) illustrates the incidence of HIV in this population by study period. Overall, an average of 34 HIV-positive women gave birth to live children per year. Before the advent of pre- and post-natal AZT therapy, five or more of those babies were potentially infected. With AZT therapy, the incidence of infant infection has dropped to one in 10. This dramatic change provides an unquestionable reason why health care providers

should counsel women of childbearing age about knowing their HIV status, and of the availability of AZT if they are HIV-positive and pregnant.

Delaware Addresses the Need to Prevent Further Spread of HIV Infection

The *Comprehensive HIV Prevention Plan*, a recently revised document (September 1995), is now available. It is a handy reference guide to the workings of the statewide community initiative to address problems created by HIV infection in the state. Compiled cooperatively by Delaware Health and Social Services' Division of Public Health and the Prevention Committee of the Delaware HIV Consortium, the document contains information on the status of the epidemic and identifies priority programs directed to communities at highest risk.

A copy of the *Comprehensive HIV Prevention Plan* can be mailed to you by contacting Jeannette Killen, Division of Public Health at (302)739-4744.

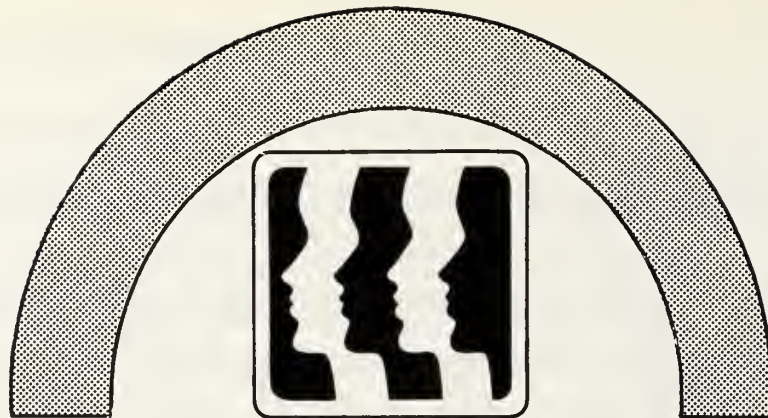
Demographics of AIDS Cases Reported in Delaware through May 31, 1996

EXPOSURE	MALE		FEMALE		TOTALS	
	All Cases	1996 Cases	All Cases	1996 Cases	All Cases	1996 Cases
Homosexual or Bisexual Man	577	27	0	0	577	27
Injecting Drug User (IDU)	493	56	191	19	684	75
Homo/Bi IDU	103	2	0	0	103	2
Hemophilia	6	0	0	0	6	0
Heterosexual Contact	49	3	109	9	158	12
Transfusion-related ¹	6	0	12	1	18	1
Parent HIV-infected	4	0	7	1	11	1
Under Investigation	58	20	18	9	76	29
Totals	1296	108	337	39	1633	147

¹ Of the 18 transfusion-related cases in Delaware, one was given blood supplied by the Blood Bank of Delaware and that transfusion occurred before HIV-antibody screening became available.

AGE	All Cases	1996 Cases	RACE/ETHNICITY	All Cases	1996 Cases
Under 5	12	1		548	32
5 - 12	1	0	White, not Hispanic	984	100
13 - 19	5	1	Black, not Hispanic	93	15
20 - 29	260	14	Hispanic	6	0
30 - 39	815	75	All others		
40 - 49	394	37	Totals	1633	147
Over 49	146	19			
Totals	1633	147			

COUNTY OF RESIDENCE	Alive	Dead	Total		YEAR OF DIAGNOSIS	Cases	Dead
Kent Co.	67	87	154		1981	1	1
New Castle Co. (outside Wilmington)	195	296	491		1983	3	3
Wilmington	349	405	754		1981	5	5
Sussex Co.	89	145	234		1985	17	17
Totals	700	933	1633		1986	36	36
					1987	39	37
TOTAL U.S. CASES REPORTED					1988	77	69
May 1994 through April 1995		May 1995 through April 1996			1989	79	69
78,242		71,323			1990	107	88
April, 1996 AIDS statistics from the Centers for Disease Control and Prevention (CDC) show 528,287 adults and 7,165 children under 13 for a total of 535,452 cases.				1991	124	100	
				1992	259	182	
				1993	262	155	
				1994	286	106	
				1995	262	57	
				1996	76	8	
				Totals	1633	933	



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9-12

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4-6

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SCHOOL HEALTH TALKS

School Health Talks for 1995-96

The program has ended its sixth year. To date, there are 28 topics and Sexual Harassment is the new topic this year. One talk was given that was not on list: Health & Disease. 77 talks were given this year.

An asterisk is placed before the most frequently requested topics and the number of times the topic was requested follows the topic.

The Aging Process	1	* Prevention of Teenage Violence	6
AIDS	0	Puberty	0
Alcoholism	1	Self-Esteem & Assertiveness	2
Anxiety & Depression	0	Sexual Abuse	0
* To Become a Family Physician	4	Sexual Harassment	0
Breast Self-Examination	0	Sexually Transmitted Diseases	1
Cholesterol & Diet	0	Sexual Development	0
Date Rape	2	Skin Cancer	0
* Drug Abuse	10	* Smoking	5
Eating Disorders	0	* Steroids	12
Fetal Alcohol Syndrome	0	Stress	0
Health Problems of Minorities 1		Teenage Pregnancy	2
* Hearing Damage —		* Teenage Suicide	16
or Loss from Loud Music	9	Testicular Cancer	0
Nutrition	2		

Physicians who participated:

Rhoslyn J. Bishoff, MD
Richard B. Crabb, MD
Jack Dilts, MD(non-member)
Sally H. Dowling, MD
Pamela J. Forest, MD (non-member)
Robert W. Frelick, MD
Casey J. Graybeal, MD

Patrick A. Jarvie, MD
Francis P. Martin, MD
Allston J. Morris, MD
Stuart A. Narrod, MD
David Platt, MD (Medical Coordinator for
Physicians and Educators for Improved Student Health)
Albert A. Rizzo, MD
William D. Shellenberger, MD

MSD members are encouraged to participate in the school health talks for 1996-97. Talks are given to all grades first through twelfth, and can be scheduled around your availability. For more information about participating in this program, contact Lauryn Harkness, administrative coordinator, at the Medical Society of Delaware (302-658-7596 or 800-348-6800).

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MSD MONTHLY ACTIVITIES

Working for You: August 1996

Leadership Activities

- Garth A. Koniver MD, Mark A. Meister, Dace Blaskowicz met for a quarterly review of investments.
- Mr. Meister and Beverly Dieffenbach met with Rochell Dolego of Glaxo.
- Mr. Meister and Ms. Dieffenbach participated in the Medicaid Interview regarding managed long term care.

Physicians' Advocate Program Activities

- Mailers have gone out for the remaining six fall workshops, beginning with a workshop September 25 on Human Resources: Labor Boards and State Agencies - How to Deal With Them.
- Medical offices continued to generate questions and request information with a record 198 contacts in August.
- Physicians' Advocate provided consulting to three area practices and assisted another physician starting a solo practice. This included interviewing and hiring initial office staff as well as providing credentialing and start-up preparations.
- Physicians' Advocate attended the August Medicare Carrier Advisory Committee and the CVO Steering Committee meeting. A presentation by the Physicians' Advocate was made at the Psychiatric Society of Delaware Council meeting regarding the BCBSD deselection issue.
- Physicians' Advocate continued working

with: Xact Medicare, HCFA, LabCorp, Medlab regarding coding and billing requirements for clinical laboratory services.

CREDENTIALING CONNECTION Activities

- Incorporated CREDENTIALING CONNECTION as for-profit entity.
- Began creation of bylaws
- Statewide mailing sent to all practicing physicians in the state of Delaware
- Mailing sent to all MCOs and Hospitals

Continuing Medical Education Activities

- Sponsored 8 educational activities for Category 1 credit.

Major Meetings

- Budget and Finance Committee Meeting
- Physicians' Health Committee Meeting
- Personnel Committee Meeting
- Committee on Aging Meeting
- Delaware Health Information Network Meeting

United Way of Delaware A New Generation of Caring



For fifty years, United Way of Delaware, formerly the United Fund of Wilmington, has dedicated itself to one mission: to maximize the community's resources to improve the quality of life for Delawareans. United Way does this by providing crucial financial support to its member and affiliate agencies so they can reach out to others with their programs. These programs touch young and old, physically mentally and economically challenged, as well as those battling addictions and seeking sanctuary and solace.

When we as physicians support local agencies through United Way, we are serving the community by helping to ensure that vital human resources are just a phone call away. It is through the agencies' valuable work that we are able to meet many societal needs. They enable us to recognize the potential in our young people and to address the unique concerns of growing older; to meet the needs of the physically and mentally challenged and to train those in search of employment; to offer effective treatment to those battling addictions and to provide a haven and new hope for the homeless and abused.

Together, the 87 agencies and the United Way of Delaware have indeed made significant strides toward positive change in the communities in which you and I work and live. However, as the needs continue to grow, we must renew our commitment to meeting these needs. In the future, as we strive for an ever better quality of life, *we must redouble our efforts* to provide the funds that make change possible and in turn, effectively serve our community.

This past year has been one of revitalization for the United Way of Delaware. We look toward the future with anticipation as we build upon the momentum generated during the last campaign. United Way of Delaware has set an aggressive goal of \$20 million for the 1996 campaign. We seek to meet this goal and reach new heights as we continue to serve our community by providing increased financial resources to our agencies.

The goal we have set for ourselves in the physician's community is \$85,000. When we meet this goal, there is a corporate incentive of \$5,000 to be split between two agencies which provide medical services to the less fortunate, the Claymont Community Center Health Clinic and the Kent County branch of Family and Children Services.

The Claymont Community Center Health Clinic provides patient medical assessment and examination, referral, health promotion screening, coordination of volunteer physicians, medical records management, and case management of complex cases. Services will expand in 1996 to include Medicare approval and special outreach health screenings in the community.

The Family and Children Services' program that will receive the incentive dollars is the ARC (A Resource Center for Youth) program in Kent County. ARC provides medical services to adolescents under the age of 19 in Kent County. These services include exams for contraception, confirmation of pregnancy, diagnosis and treatment of sexually transmitted diseases, as well as all related lab work.

Please, when your solicitation arrives in the mail, be as generous as possible. In partnership with the people of Delaware, we can indeed create A New Generation of Caring.

Garth A. Koniver, MD
Chairman, Physicians Division
1996 United Way of Delaware Campaign

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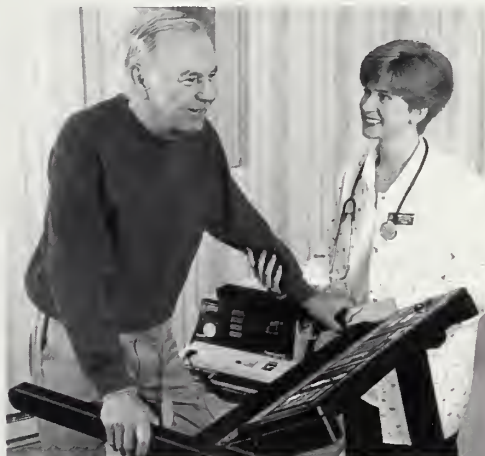
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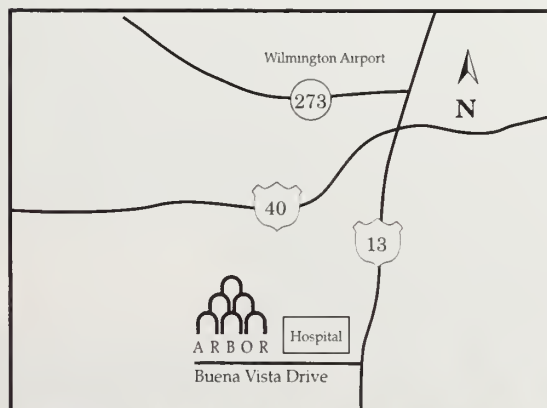
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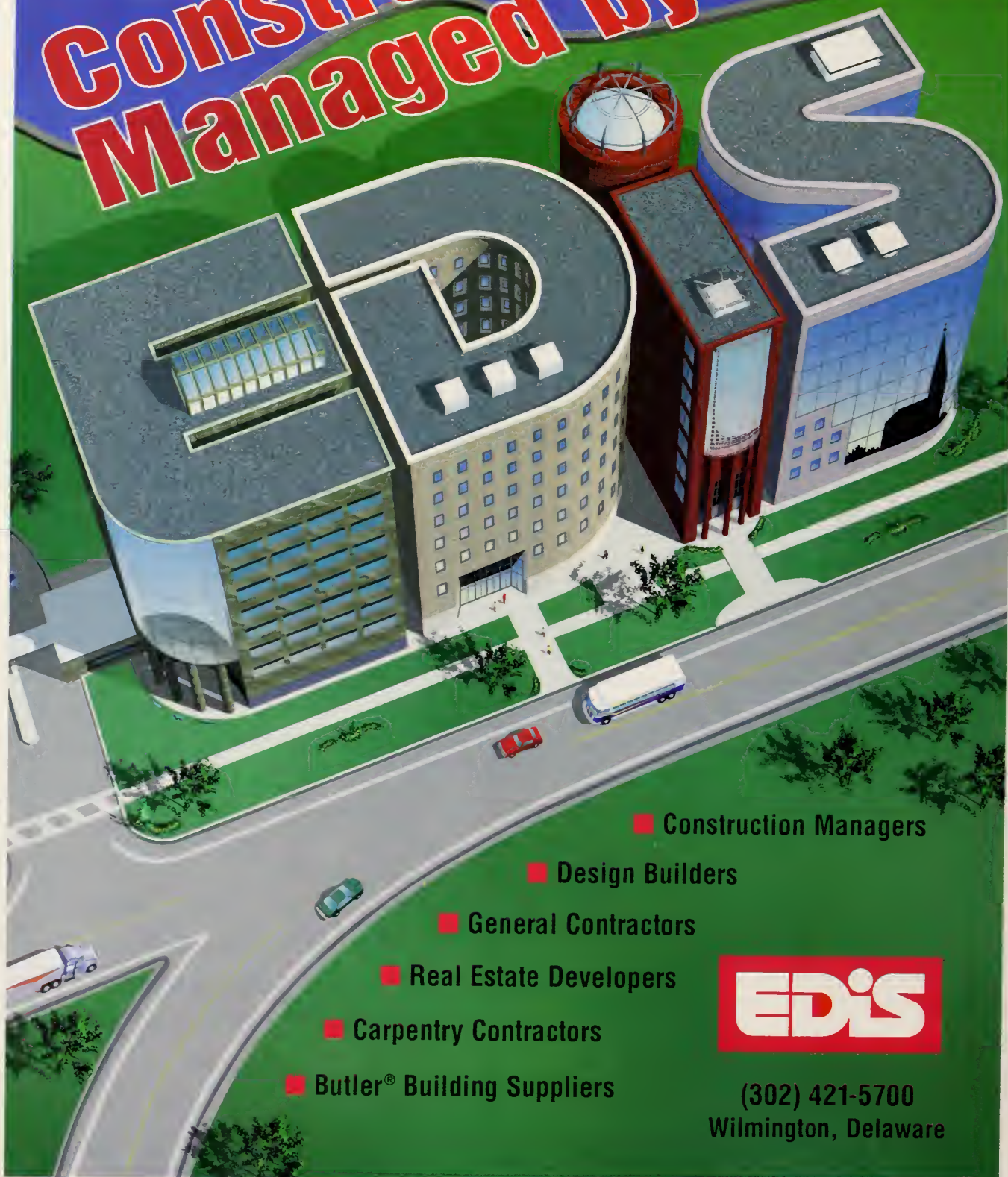


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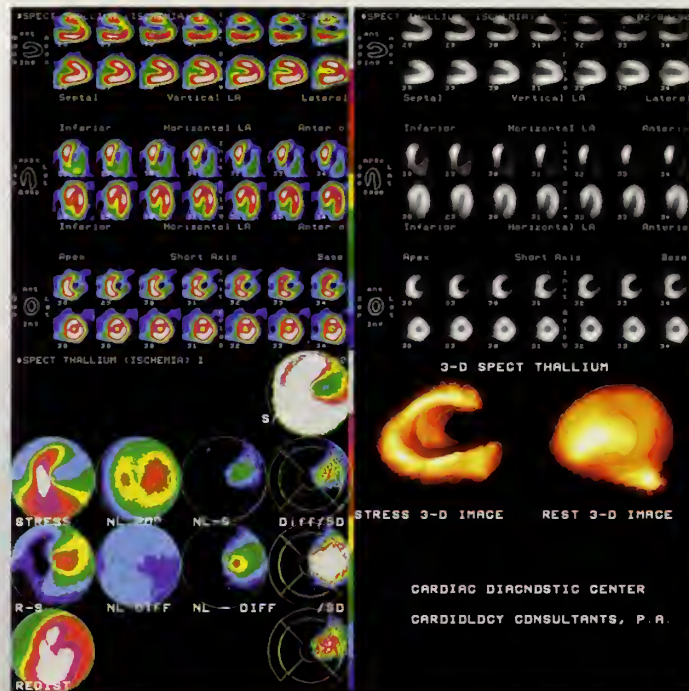
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Scientific articles on medical matters are especially welcomed, including case reports, clinical experiences, observations and information on matters relevant to medical practice. Other material may also be accepted if the editorial staff deems it of interest to *DMJ* readers. All submissions should include a brief summary.

It is highly recommended that authors familiarize themselves with *DMJ* style before submitting manuscripts for consideration.

All material for publication should be submitted either on a 3 1/2" computer diskette in WordPerfect 6.0, or typed or printed out on good-quality paper (one side only, double-spaced, one-inch margins). The ideal manuscript length is two to 12 pages. Up to 12 references per manuscript will be accepted, each keyed with superscripts in the text in the order cited. The format should follow that used in the *Index Medicus*. Authors are responsible for the accuracy of the citations.

Graphs, charts and black-and-white glossy photographs are accepted if important to the understanding of the text, but should not exceed four or five pieces. Each should have a label affixed on its back indicating its name, number, and "top." A separate legend should be provided for each. Do not write on the back, or scratch or mar them using paperclips. Do not mount them on cardboard.

Photos of patients should generally be taken in a way that obscures the patient's identity. Photos in which a patient's face must be clearly see, however, must be accompanied by signed release forms.

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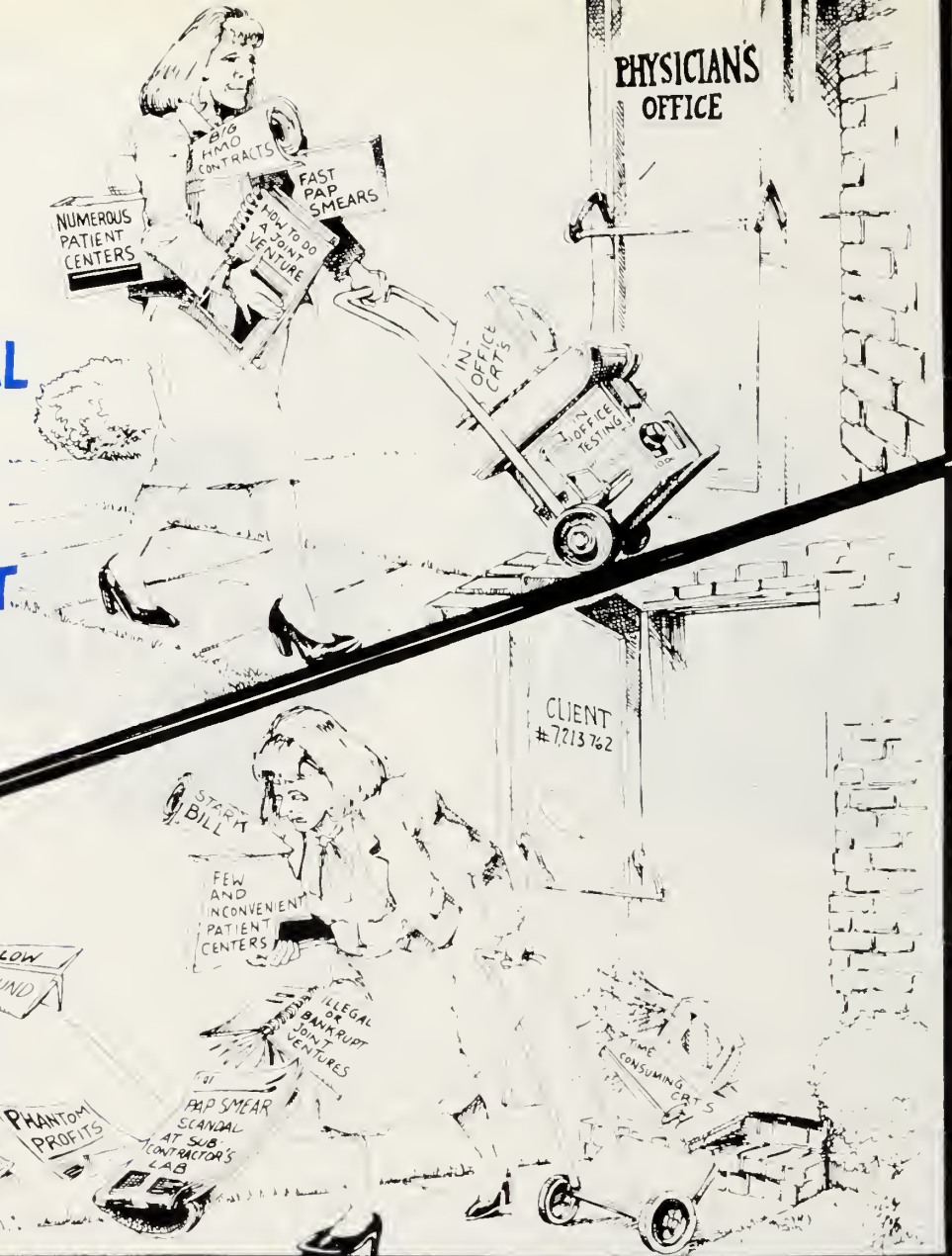
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The President's Annual Report

This year has witnessed tremendous activity on many fronts. An overview of the President's activities over the past year is as follows.

In the legislative arena, great efforts were put forth regarding HB 321. The bill got tabled because of an amendment, but its principles will be back. It sought to manage managed care, requiring that payors make their criteria for inclusion/exclusion on panels known; require that employees be allowed to purchase point-of-service plans if they so chose; and that the "industry" be regulated. Although it didn't pass this time around, the consciousness-raising that the discussions provoked have led to related legislative gains.

The leadership has met on numerous occasions with our key legislators, both state and national. We have had regular meetings with the Governor and the Secretary of Health and Social Services, as well as with our Senators and Congressman.

Meetings with Blue Cross/Blue Shield of Delaware have been held, in particular with regard to its recent acquisition, in terms of the impact upon physicians and their practices, and also in order to give physician input. Similarly, a recent meeting with Aetna/US Healthcare served to establish the Medical Society in a consultative role in the evolution of that merged entity's activity in Delaware.

Interface with other health care providers, in the spirit of collaborative interactions which optimally complement rather than compete, have continued. This year, there has been emphasis on the pharmacists, who are

developing "cognitive services," which would be reimbursable; the Medical Society has been emphatic that physician input be an essential here.

The Centralized Credentials Verification Service is up and running, an endeavor which will simplify life for all Delaware physicians, in *greatly* reducing the angst of participation and recertification in the various health care plans.

The Physicians' Advocacy Program has continued in its popularity, with Jana Siwek providing invaluable on-site assistance to physicians' offices and staff, and facilitating interfaces with third party payors.

The Medical Society's Contract Review program continues to provide helpful, pragmatic critiques of the various carriers' terms of agreement, thus making our decisions more informed.

More workshops have been held with an expanded schedule over the past year, as well as the Second Annual EDI Expo, which was once again well-subscribed.

Our recent Candidates' Night provided a close-up look at the hopefuls for the November 5 election, with near-unanimous participation by those in the running, and opportunity for individual questions.

The Physicians' Health Committee has continued in its mission of assisting physicians with various difficulties. This year has seen a major effort to formalize, clarify, and enhance its relationship with the Board of Medical Practice.

On the national level, the Society has

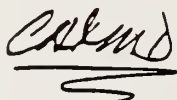
worked hard to provide input into health care issues, such as the conference call your Executive Director and President engaged in with Senator Roth's Washington Office, regarding improvements in the fraud and abuse provisions of the now-passed Kennedy-Kassebaum Bill. Those improvements were, in fact, realized.

The delegation to the AMA has represented Delaware at the Annual and Interim Meetings of the House of Delegates (these have been summarized in this year's President's Pages).

Your President has represented the Society at many, many functions over the past year, both locally, such as the Annual Meeting of the Pharmacy Society, Dental Society, American Red Cross, American College of Surgeons, Philippine-American Medical Society, and others, including our own Alliance's Annual Meeting, and regionally, at the House of Delegates and Annual and Interim Meetings of our neighboring states, as well as at the AMA, serving as Alternate Delegate as well as representing the Society at the Organization of State Medical Association Presidents. Numerous meetings have also been held with members of the AMA's Board of Trustees, on various, timely issues.

Perhaps the farthest reaching activity of this year has been that concerning the facilitation of physician organization (the theme of my presidency) - the formation of Med-Net, the Society's Managed Care Strategy Initiative, to give physicians the tools they need to organize themselves and present a powerful, unified voice and remain at the helm of medical decision-making, and to facilitate and catalyze this process.

The aforementioned activities are not all-inclusive, but represent the highlights of the President's activities and involvement on behalf of the Medical Society. It has been an honor and a privilege to serve and represent my colleagues in this manner, and I shall be ever grateful for this very special opportunity.



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INTRODUCTION

Physician Assistants

E. Wayne Martz MD

Every country in the world has trouble recruiting fully qualified physicians to practice in rural and small town areas. Even dictatorships and highly regimented societies experience this. It is probably not reasonable to expect people at or near the top of their college class who then go on after graduation to four more years of education and three additional years of intensive training, to live and work in these areas for very modest incomes. Missionaries and saints are few and far between. The only solution which has worked at all has been for people with less extensive education to take these positions, provided they are taught to recognize which problems are beyond their competence levels and refer them. In other words, make them safe doctors for an entry level of care. In our society this involves the use of physician extenders. These come in two varieties, Advance Practice Nurses (APNs) and Physician Assistants (PAs). The APNs can be further broken down into Nurse Midwives, trained by physicians and nurses, Certified Registered Nurse Anesthetists (CRNA), trained by physicians and nurses, and Clinical Nurse Specialists, trained and educated by nurses. This latter group may specialize in any of a number of clinical disciplines — e.g. pediatrics, family practice, etc.

It is clearly the objective of the APNs to practice as independently as possible, and after years of intensive lobbying in the Delaware legislature, they achieved this in 1994. They must have a sponsoring physician whom they can consult, and some agreed upon

“practice guidelines”, but it is not required that their work be reviewed and they consult the physician only when they choose. They can write prescriptions, and have billing privileges.

Physician Assistants, on the other hand, are trained largely by physicians, and their objective from the beginning is to work with and under the supervision of physicians. Most physicians find it easier and more comfortable to work with PAs than with APNs, and it tends to establish one level or standard of care rather than two.

There follows a write-up I am reprinting with permission from the South Dakota Journal of Medicine. In a state as spread out as South Dakota the extensive use of physician extenders is absolutely essential. In Delaware such a move is optional. Licensure of PAs was approved in Delaware in 1991 and their practice was expanded at the urging of the medical society at the same time APNs were granted more freedom. We have the capability of training PAs here in Delaware, though there are no accredited schools at present. Some feel that if such a school is started it should be located in central Delaware, thereby attracting largely applicants who would be comfortable in Kent and Sussex Counties. It could also be assumed that the doctors of southern Delaware, if it is their own program and they do the training, will know well the abilities and limits of their students, and would be more inclined to hire them when they graduate.

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PA's — Physician Assistants

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The physician assistant profession is about thirty years old. In its short history, it has had an important impact on the delivery of quality medical care. There are approximately 27,700 physician assistants, or PAs, currently practicing in the United States and approximately 175 in South Dakota.¹ Therefore, it would not be uncommon for a physician to have never interacted professionally in medical school, residency programs, and practice environments with PAs. The purpose of this article is to present to the physician what a physician assistant is and the relationship between physicians and PAs.

Physician assistants are certified health care professionals who practice medicine with physician supervision. They perform a wide variety of medical and surgical services, as delegated to them by their supervising doctor, that were traditionally provided by only physicians. In fact, the literature indicates that PAs can substitute for physicians in anywhere from 75 percent to 90 percent of primary care functions.² Although they are

dependent practitioners, they do exercise a degree of autonomy in the diagnosis and treatment of illness. They can be found practicing medicine in diverse settings — from remote rural communities to urban cities and from primary care to surgical subspecialties. In South Dakota about half of physician assistants practice in rural sites.

The average PA program is over 25 months in length, or another way of looking at it, 108 weeks for the average PA program compared to 153 weeks for the average amount of time spent by a medical student in medical school. The majority of PA students have a bachelor's degree and over four years of health care experience before entering a program.³ Generally, the first year consists of didactic training in medical science. The second phase consists of clinical rotations where the students are involved with direct patient care.

The University of South Dakota School of Medicine, Physician Assistant Studies Program was developed following the action of the 1992 South Dakota legislature and graduated its first class in 1995. The USD Physician Assistant Studies Program has now graduated 23 individuals and of the 23, 19 or 83 percent, are now practicing in Family Medicine. Currently the program has 16 second year students doing clinical rotations and 16 students involved in the didactic phase of their training. The mission of the USD PA Studies Program is to help meet the need for quality primary care providers in rural South Dakota. The program accomplishes this by

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selecting individuals likely to practice in South Dakota, who have the academic, clinical and interpersonal aptitude necessary for the education as physician assistants.

Upon graduation from an accredited program of instruction, the PA must pass a national certifying examination developed by the National Board of Medical Examiners and administered by the independent National Commission of Certification of Physician Assistants (NCCPA). The USD PA Studies Program received accreditation in 1995 and students taking the test for the first time achieved a 91 percent pass rate compared to the national average of 78 percent. Passage of the examination gives the PA the right to use the designation, "PA-C", or physician assistant-certified. In order to maintain this certification, the PA must log a minimum of 100 hours of CME every two years and retake the written examination every 6 years.

In 39 states, Guam, and the District of Columbia, physician assistants are permitted to prescribe medications. In South Dakota, PAs have prescriptive privileges. Additionally, the rules and regulations for PA practice vary from state to state. For more information, contact the South Dakota Board of Medical and Osteopathic Examiners at 1323 South Minnesota, Sioux Falls, SD 57105.

Recent studies indicate that in many practice settings PAs are being underutilized. Research conducted by Kaiser Permanente suggests that this is partially due to the comfort level of the physician in delegating medical tasks to their PA.⁴ Another study conducted by the Veterans Administration also revealed that the supervising physician's attitudes and style of delegation of tasks was a greater factor in the utilization of "As than the physician assistant's education and clinical skills level."⁵

Because the physician assistants are dependent practitioners and utilization and effectiveness of them are related to the supervising physician, the American Medical Association recently released guidelines for Physician/Physician Assistant Practice. These guidelines are also endorsed by the American Academy of Physician Assistants. They are as follows:⁶

1. The physician is responsible for managing the health care of patients in all practice settings.
2. Health care services delivered by physicians and Physician Assistants must be within the scope of each practitioner's authorized practice as defined by state laws.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Physician Assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the Physician Assistant in all settings.
5. The role of the Physician Assistant(s) in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the Physician Assistant and based on the physician's delegatory style.
6. The physician must be available for consultation with the Physician Assistant at all times either in person or through telecommunication systems or other means.
7. The extent of the involvement by the Physician Assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training and experience and preparation of the Physician Assistant as determined by the physician.
8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a Physician Assistant.
9. The physician and Physician Assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the Physician Assistant with his supervising methods and style of delegating patient care.

(Note: Copies of the guidelines can be obtained by contacting the AAPA Public Affairs Office at (703)836-2272, ext 3505.)

Several recent studies have examined the

quality of health care provided by physician assistants. Six reviewed data from over one dozen studies on the clinical performance of PAs and concluded that the care they provide was "indistinguishable" from the care provided by physicians.⁷ According to a recent article in *JAMA*, the US Congress' Office of Technology Assessment concluded that the quality of care by non-physician practitioners is "equivalent to the quality of comparable services provided by physicians".⁸

This same article also examined indirect indicators of quality, such as physician acceptance and patient satisfaction; these parameters also reflect PAs in a favorable manner.⁹ The US Department of Health and Human Resources' Physician Assistants in the Health Workforce Report of 1994 cites a high level of patient acceptance and satisfaction with the care they received by PAs.⁷

A recent report by the American Medical Association regarding PAs employed by solo physicians looked at the effect of physician productivity and other practice characteristics. The findings suggested, "The incentives for employing non-physician practitioners include increases in net income and physician productivity — office visits per hour, and visits in all settings, both on a weekly and yearly basis. By employing non-physician practitioners, solo physicians were able to expand the scale of their practices and provide greater access to care." In a report in 1995, the Medical Group Management Association, suggests that although PAs generally do not see as many patients per year as family practice physicians, their "lower average salary and productivity make them economical providers."¹¹

In conclusion, physician assistants are providing quality, cost-effective health care with the supervision of physicians. They are dependent health care practitioners as members of the health care team, yet capable of exercising a degree of autonomy in medical decision making. In the provision of quality health care for the citizens of our state, physician assistants are professional assets.

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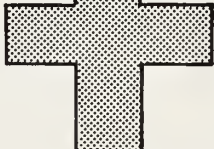
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Managed Care for the Millenium

Robert L. Meckelnburg MD

It is no surprise that physicians have been buffeted and bedeviled for the past decade not knowing how to react to Managed Care. The onslaught of this new phenomenon has left many of them disheveled and completely out of touch with any reasonable guideline for re-orienting their practice or their lives. Never has it been more important to know and understand all the stakeholders participating in the medical environment today. Let no one be mistaken. Insurance carriers are certainly the heavy hitters of the Managed Care environment, and they have demonstrated the principle that physicians now have to wholeheartedly embrace.

That principle in the new environment is to gain control of the money. In most instances this will mean direct contracting with employers or service groups. Most physicians in nuclear medicine will feel that they have little bargaining power to make such decisions, but all of us are part of one group or another, and we can make our voices heard and the logic of our thinking understood. Across the country the most successful groups are those networks of physicians that accept full risk capitation directly from purchasers of health care and bypass insurance companies and other managers who interlope in the medical environment. These groups have established themselves not with expensive hospitals or high tech equipment but they have organized themselves with an information

network that streamlines their operation and most importantly allows them to know their day to day expenditures. As you are probably aware, the failures when they did occur in these groups, was due to the lack of knowledge about what was being spent on a day to day basis.

Why not be capitated under an insurance company or an HMO you might ask? For some groups this capitation approach has been financially successful but in others it has been exceedingly difficult and in some instances, resulted in failure. Ask any one from the Mulliken group in California what successful operation meant for them. They undoubtedly are one of the most efficient, well-organized health care delivery systems in Southern California. They had the lowest operating cost, the fewest number of hospitalization days per thousand and their overhead was minuscule. When they went to re-negotiate their annual contracts, the insurance carriers didn't congratulate them on their frugality. On the contrary, they reduced their contract even further. Mulliken almost went to the wall. Of course, patients rarely see the rewards of these increased efficiencies as premium reductions, but you can rest assured that there is no drop in the profit margin of the managed care organization. Allowing someone else to control the money is a prescription for disaster.

Where is the concern of publicly traded corporations? Are they something totally new to Wall Street? Absolutely not. One does not go public to become a mendicant monk. The purpose of being on Wall Street is to make a profit. When you go to a stockholders meeting

Dr. Meckelnburg is in private practice in Delaware and is the President-Elect of the American College of Nuclear Physicians.

do you think they are discussing quality of care or the nuances of outcome research? Even the medical community has trouble measuring quality of care and outcomes research has barely seen the light of day, and there are grave questions as to whether significant data will ever be generated on most subjects.

Hark back to the outcomes research attempted some 18 years ago with oral anti-diabetogenic agents (an enormous study with thousands of patients, hundreds of statisticians and few meaningful results). What you do hear in the stockholder meetings however is this question, "Where is the bottom?" What is being referred to is the point at which the reimbursement to a provider is so low that he will no longer choose to stay in business but will close his doors. It is at this point that third party negotiators know they can truly control the market, dictate wages for providers, shift all risk and keep all the profit that the market will bear. This is the ultimate goal of all for-profit operating businesses, and it is only a high level of competition that keeps any one company from achieving its maximum aim. The fundamental reason behind the recurring run-up in healthcare stocks is this belief that we haven't reached the bottom as yet and therefore there is still a lot of profit that can be wrung out of the industry.

No one should be deluded for a moment that there is a benevolent overseer whose purpose is to protect and provide for physicians. Actually society did that up until about 20 years ago but now medical care has become so impersonal and technologically oriented that it is just another commodity to be bought and sold by the lowest bidder. Physicians have unfortunately distanced themselves from their patients. A recent Gallup poll discovered that the minimum amount of money necessary to induce patients to change physicians was \$5.00. The point of this discussion is that the only way physicians can be comfortable with the changes occurring in the marketplace is to be able to control decisions about the amount and type of care a patient should receive dependent upon his diagnosis. To have this final say you must control the money.

Choose Your Hospital Wisely

Most nuclear medicine physicians are closely aligned with one or more hospitals. They usually operate out of these facilities not owning equipment nor worrying about overhead. Many physicians in such situations are still on fee for service but this is rapidly changing. Within the next several years physicians aligned with hospitals will have to be on salary or controlled income since this is the only way a hospital can competitively bid health care contracts. It then becomes a problem of how the nuclear medicine physician will be reimbursed and what formulas will be used to arrange this compensation. The tendency in the past several years has been to use the RBRVS schedule for baseline calculations. Other methodologies will certainly be employed. Tighter controls over technologists and their numbers and hours of employment will also be inevitable. Hopefully cost of equipment will be reduced and overhead from that standpoint become more manageable.

A growing trend is to have nuclear medicine facilities move out from the hospital and ensconce themselves in lower overhead operations. The advantages for outpatients are obvious and this will be a more competitive operation. Unfortunately most hospitals are still operating on the supply side of the economics question and this runs counter to what managed care organizations want to have happen. Hoping to keep beds filled by alliances and mergers will only be successful for less penetrated communities. Under full capitation hospital beds will become the dinosaurs of the medical field. Mergers have the potential of producing redundancy and some practitioners may lose their operating base.

Knowing what is going on in your own neighborhood is a vital necessity. Having a contract for as long as possible is a recommended procedure. Accept what terms you can negotiate but make your goal the longest term possible. The chance that the present trend can be reversed is slim and you want to be covered for any eventuality. Remember that what has happened in industry will happen in medicine. Mergers presage de-merger, so spinning off units and sections that don't seem to fit will be the next period of conten-

tion for practitioners. Again, wisely assessing your alternatives is the best advice. Such changes may continue for the next five to ten years. Steven Shortell wrote about these exact changes beginning in industry in the late '60s and early '70s. Industry is still going through virtual integration and medicine will follow in its footsteps.

Where is the best place to be? It would appear that the most successful groups of the future will be physicians organized into networks spread across large areas of the population and able to take full responsibility for the care of those patients. They will negotiate for all the services they don't provide from the lowest bidder. These groups will still monitor access and service and follow their patients' diagnostic and treatment process quite closely. They will negotiate directly with payers for managed care contracts. Most importantly, management decisions will be made at this local level and providers will be involved in those decisions.

Finally physicians will have to learn to network and reach out to those around them to develop interacting services that will

complement their individual activities. The days when physicians could operate on their own are rapidly coming to an end. Imaging networks are being spawned that will cover 10, 20, or 30 hospitals with interpretation of studies done at one single site and results fed back to the individual hospital. Physician staff can be reduced and turnaround time not greatly affected. Economically the advantages could be quite compelling.

Network

To compete with this type of activity, physicians need to form their own networks so that they can provide a greater range of service, more hours of operation and greater degrees of flexibility in serving the patients. Being all things to all people can't be done by one person.

One starts networking by meeting and talking to people. We need to exchange thoughts and ideas, problems and aspirations, goals and desires, but the major emphasis of all parties has to be to cooperate to produce a better product.

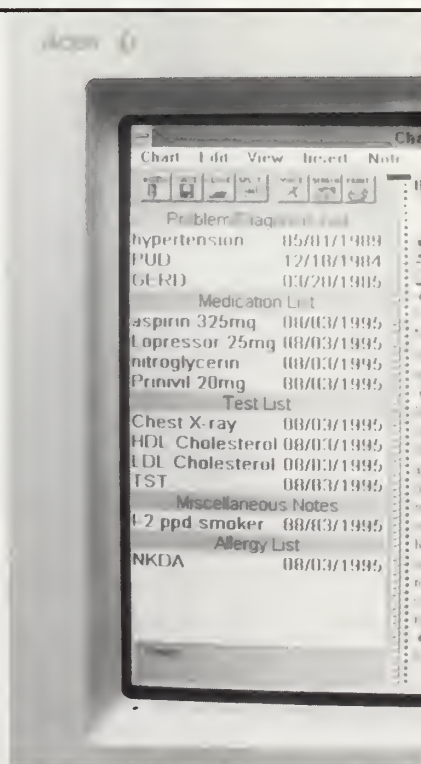
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50,000 Killed; Cost \$1 Billion

Edward Sobel DO

Reprinted from Quality Time(a quarterly update of the West Virginia Medical Institute's Health Care Quality Improvement Program), Special "Say No to Bugs" Flu issue 1996.

At first glance, you would look at these headlines and think I copied them from a super-market tabloid and guess the story was about chickens dying downstate in a heat wave and the resulting economic lost. But I am not. I am talking about people dying and tax dollars being wasted.

The General Accounting Office estimates that approximately 20,000 people die annually from complications of influenza, and 30,000 die from pneumococcal disease, most of those being elderly patients. It costs Medicare almost one billion dollars to reimburse hospitals for treatment of flu and pneumococcal disease.

This is a national scandal. If this were the result of an industrial accident, a nuclear explosion, or the work of a madman, this country would be up in arms. But this is an annual crime that goes basically unreported and untreated year after year, and to a large degree, we as health care providers do nothing to stop it, despite having the tools at hand.

The tools are simple: influenza and pneumococcal vaccine. Both are available without charge to Medicare patients, and I suspect that virtually every primary care physician and many of the specialists such as pulmonologists and cardiologists have sup-

plies in their office refrigerators. Despite this, statistics show that only about 50 percent of eligible Medicare patients get flu vaccine, and only 27 percent have gotten pneumococcal vaccine (1993 figures). Why is this?

Studies to find out why the rates are so low show the following statistics among recipients:

- Only 25 percent of all adults over 55 years of age were aware of pneumococcal vaccine.
- Many elderly do not see themselves as susceptible to flu or pneumonia because they are "healthy."
- Flu and pneumonia are not perceived by many elderly as serious diseases.
- Seventy-three percent of elderly believe that flu vaccine caused illness, did not protect against flu, or was unnecessary. Thirty-six percent believed that pneumococcal vaccine did not prevent pneumonia or would make them sick.

Among physicians, only 50 percent recognize age over 65 as an indication for vaccination. A minority have doubts as to the efficacy of vaccines, and only 70 percent believe flu vaccine is safe and effective for at least 60 percent of patients.

If we are to be the providers of health care and health information to patients, if we are to be the advocates we claim to be for our patient's health, then what must we do?

- Inform ourselves about the vaccines, just as we do for other medications, procedures, etc.
- Talk to our patients about the vaccines

when they come to the office. In a study, when physicians recommended vaccine, almost 90 percent of patients took the shots if they had a favorable attitude toward vaccines. Amazingly, 70 percent of patients with negative attitudes took vaccine if recommended by their doctor!! This compares to only 9 percent of patients who got vaccine if their doctor said nothing and they had negative attitudes.

- Be prepared to discuss patient objections which can include:

- I'm healthy and don't need it.
- You can get the flu after getting the shot.
- The shot causes the flu.
- There are lots of side effects.
- I got the shot before and got the flu.
- I don't like needles.
- I don't want to waste money.

- Remember to tell patients about the vaccine. In a focus group of internists, many said they forgot to tell the patients about the vaccine!

- Vaccinate all of your nursing home and hospitalized patients. A significant percentage of hospitalized patients are readmitted within 5 years due to complications of flu or pneumonia.

- Send reminders to patients. Studies show a 100 percent increase in immunizations by mailing a postcard to your patients. Even a little reminder on your billing statement could be of value.
- Set up an office reminder system. Have a checklist in your chart. If you have computerized records, build in a pop-up screen.
- Have standing orders for your staff to immunize.

- Develop an incentive system for your staff so that patients are reminded by the nurse, receptionist, or telephone operator.
- Encourage patients to use senior center vaccination programs if they so desire.

As part of the HCQIP effort that has included provider centered projects such as the Cooperative Cardiovascular Project (CCP) and the Atrial Fibrillation and INR studies, this fall WVMi will be sponsoring a Medicare consumer oriented flu/pneumonia vaccine campaign in Delaware as part of a national effort by HCFA to end this national scandal (see page 2). Make this fall an opportunity to make a difference in your patients' futures.

Beneficiary Project Targets Flu Vaccinations in African American Community

The low number of influenza vaccinations among African American beneficiaries is a health care concern nationwide and in Delaware.

Nationally, the claims rate is about one-half that of the rate for Caucasian beneficiaries. In Delaware,

the difference is 23 percent versus 39 percent. As a result, WVMi is developing a project to boost vaccinations among African American beneficiaries in New Castle County.

WVMi is targeting New Castle County because 61 percent of African American beneficiaries reside there. In addition, the disparity between African American and Caucasian vaccination rates is even more evident (24 percent versus 42 percent).

WVMi's objectives for the project are to increase awareness and increase the number

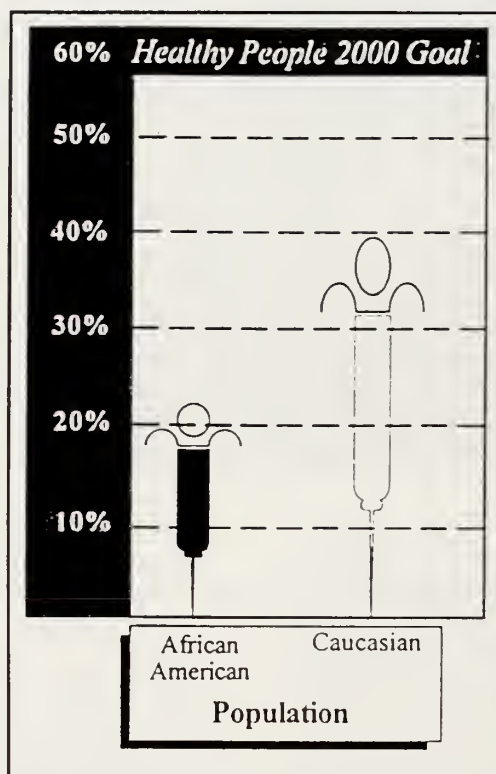


Figure 1. 1994 Delaware Flu Vaccination Claims Rate

of Medicare-paid flu shots given to African American beneficiaries. WVMi hopes to accomplish these tasks through cooperation. A coalition of the Beneficiary Liaison Committee, African American churches and ministers, senior centers, businesses, the Delaware Department of Public Health, and the American Lung Association has been established to carry out the project.

The project will include letters, community partnerships, immunization clinics, incentives for vaccination, educational efforts, media coverage, and outreach to physicians.

The WVMi staff is currently preparing materials and creating messages for the campaign. In mid-August, a focus group of African American beneficiaries will evaluate and help refine the materials. In late September, the coalition will launch the educational campaign.

If you would like more information or are interested in participating in this project, call Laura Gandee, WVMi Communications Director at 1-800-642-8686, ext.278.

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The AMA Position — Physician-Assisted Suicide

As a physician, I am devoted to healing and to relieving suffering. I am obligated and committed to helping patients in their remaining days. I cannot be the cause of their death, nor can I assist them in causing their own death.

The fear associated with physical suffering, with losing control and with being a burden to or dependent upon others is understandable. However, the realities of death are a critical foundation of life. If we literally remove individuals from having to deal with these realities, it could have serious ramifications for society as a whole.

My patients must know wholeheartedly that I am devoted to their health and welfare, not deciding their fate based on what I, or others, perceive to be the value of their remaining life. Make no mistake, when it comes to caring for my patients' health and welfare, I am their trusted ally. My patients can have faith that I will do all I can to assure that their passing is dignified and comfortable.

I am acting in the best interests of my patient if, while attempting to alleviate suffering and maximize his or her comfort, death is hastened. However, if the intent of my actions goes beyond comfort and focuses specifically on causing death, I am either assisting in suicide or performing euthanasia, both of which are unethical. Death is rarely immediate when it is not actively caused. But, the dying process can take place in comfort and with dignity.

In the case of a patient whose life is artificially extended by technology, they and their family, in consultation with their physician, may decide to withdraw that life support. The patient's ability to remove the technological barriers to natural death is paramount to their autonomy and dignity. Again, the issue is one of intent. By removing artificial life-

support, I am honoring my patient's wish to allow natural death to occur. My intent is to avoid prolonging artificially sustained life, not to cause death.

Physicians who have cared for patients and their families until and beyond death experience among the most rewarding aspects of medical practice. Death is often the most meaningful chapter of a patient's life, difficulties notwithstanding. Physician assisted suicide jeopardizes this important experience.

The American Medical Association believes the appropriate answer to physician assisted suicide is improved care through a better informed medical profession and public. We must work together to ease the dying process and preserve the significance of experiencing life's final stages. Physicians have reported that patients requesting physician assisted suicide drop the idea once they understand that comprehensive planning and palliative care are available; that their life has worth; and that they won't be abandoned.

We will continue our dialogue with those whose opinions differ from ours. We will aggressively increase our efforts to educate physicians at all levels in treating physical suffering and the psychological needs of patients at the end of life. We will work diligently to inform patients on the alternatives to physician assisted suicide, including hospice care. However, the related ethical opinions developed by the AMA's Council on Ethical and Judicial Affairs will remain unchanged.

Our overall goal is to develop an acceptable, reasoned, and realistic approach to redirecting patient requests for suicide that is based on sound ethical principles and optimal clinical care.

Time to Send Your Holiday Cards!

Each year for the holiday season many physicians and their families have a chance to donate to medical education and send greetings to colleagues in lieu of mailing individual cards.

This year, in addition to supporting DIMER through AMA-ERF, we are accepting contributions to the Delaware Medical Education Foundation (DMEF), which was established in 1992 to:

- improve the Medical Society's continuing medical education program for Delaware physicians
- sponsor appropriate programs for public education
- administer the Physicians' Health Program, with the state Board of Medical Practice, to help disabled and impaired physicians.

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Profiles in Courage

James F. Lally MD

But he has put to hazard his ease, his security, his interest, his power, even his popularity.

— Edmund Burke

In a spirited style and manner that can only be described as quixotic and with seemingly little regard for the short or long term consequences of his bold actions, Dion Ehrlich MD, started out on a course of action that was cheered and admired by many physicians. Dr. Ehrlich, a Philadelphia ophthalmologist, became the focal point for a controversy about a managed care capitation plan that would affect ophthalmologists in southeastern Pennsylvania. He refused to buckle under the pressure to join a network of regional ophthalmologists that provided care for patients enrolled by Keystone Health Plan East. He then did what most physicians would not do; he wrote to 600 patients who are part of Keystone's plan and urged them to seek out other health plans.

The expected backlash occurred, as Ehrlich was threatened with the dread of deselection and a lawsuit. Ehrlich viewed Keystone's capitated plan "as offering me a hidden financial incentive to reduce or limit care to my patients." He added, "I felt that I was being asked to serve as an advocate for the insurance company's bottom line."

The abundance of ophthalmologists in the Philadelphia area has had a disquieting effect of muzzling complaints from other physicians. Perhaps it illustrates that you don't need an Anschluss or the KGB to control people and

their thoughts; simple, unadulterated primal fear will do just fine.

Our other physician-heroes were no less courageous. In an article in the *New England Journal of Medicine*, "Extreme risk — the new corporate proposition for physicians", Drs. Steffie Woolhandler and David Himmelstein challenged the behemoth of HMOs, U.S. Healthcare. They were critical of gag rules that stifle opinions about HMOs. They also objected to U.S. Healthcare's 26 percent of its revenues going to overhead and profits when Medicare's overhead is 2 percent. They also noted that U.S. Healthcare profited \$1 million a day and had a cash reserve of \$1.2 billion.

But they were primarily critical of potentially perverse financial arrangements in which physicians can profit from not referring patients. Woolhandler and Himmelstein state, "For a growing number of physicians, income is tethered to conduct that furthers corporate profitability." Although U.S. Healthcare had terminated Dr. Himmelstein's contract, it later rescinded that and it also removed the gag clauses from its contracts. Can it be that those on the moral high ground occasionally win?

America loves its heroes. It grudgingly accepts whistleblowers, but its heroes are frequently adored. The American version of an untarnished hero is a bleary-eyed unknown pilot, Charles Lindbergh, landing at Le Bourget or the blurry television images of Neil Armstrong stepping on the moon many summers ago.

But those are larger than life heroes. Our physician-heroes would have chosen to remain sheltered from the limelight and the glare of publicity. They dared bravely because personal integrity meant more than the threat of great personal loss. Is it an exaggeration to state that those who are willing to defend the inviolability of the doctor-patient relationship or to hold fast to what they believe is an ideal in medicine may be performing an unheralded service to the health care system of this country?

John F. Kennedy concluded his Pulitzer Prize winning book, "Profiles in Courage," by writing that the stories he presented of Americans with political courage, "can teach, they can offer hope, they can provide inspiration. But they cannot supply courage itself. For this each man must look into his own soul." So, when that time comes in your medical career, and surely it will for some of us, will you be able to "look into your soul," find or summon courage, speak up and defend values that you cherish as our physician-heroes did. Will you be able to exhibit what Ernest Hemingway called, "grace under pressure?"

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OBITUARIES

Allston J. Morris MD

Charles Strahan MD

Allston J. Morris MD, one of Wilmington's early post World War II internists, died at home on August 15, 1996 of congestive heart failure. He was 76 and had lived and practiced in Delaware for the past 49 years.

A native of New Jersey, he was born in Montclair in 1920. Following graduation with a BA from Bowdoin College, he entered New York University College of Medicine, and graduated in 1944. His internship was completed at the Lawrence and Associated Hospitals in New London, Connecticut. Following this internship, he spent the next two years in the Army of the United States and was discharged with the rank of Captain in 1947.

He came to Wilmington to join the residency program in Internal Medicine at the former Delaware Hospital and finished his training in June of 1949 to begin private practice.

Tony, as he was known to his friends and colleagues, was no "stay at home person." He was very active in the medical community and its various projects. Beginning in 1965, he became the President of the Delaware Academy of Medicine.

Active on the staff of the Delaware, Memorial and Wilmington hospitals, he was involved in the consolidation when the three hospitals merged to form the Wilmington

Medical Center of Delaware in 1965. In 1969, he became secretary of the center's staff and in 1970, he became its' President until 1974.

During this time, a group of physicians organized a small medical clinic to service a much needed area in the southeastern part of the city known as Southbridge that had no medical facilities or physicians. Dr. Morris spearheaded that effort. It became known as the Southbridge Medical Activities Center and from 1968 to 1974, he was vice-president of the center. This clinic grew and today it is known as the Henrietta Johnson Medical Center.

In 1964, there was increased interest in the development of a Medical School in Delaware. He functioned as Chairman of the "Committee on Medical School Feasibility Study" of the Delaware Academy of Medicine. He was also Chairman of the Scholarship Advisory Committee to the

Delaware State Board of Education from 1968 to 1978 and chairman of the committee on public laws of the Medical Society of Delaware from 1969-1978. He was board member of the Delaware Foundation for Medical Care. In addition, he was past Medical Director of the Milton and Hattie Kutz Home.

In 1979, he was elected as Vice-President for Medical Affairs of the Wilmington Medical



Center and he served in that position for 10 years.

Well-liked by friends, patients and colleagues, he had a warm, friendly manner and the intellectual thrusts that he frequently used did not put you off. Outside of the world of medicine, he immersed himself with his family and interests in literature, music and cooking for his friends. He could do a New York Times cross-word puzzle faster than anyone I knew. Respected as an excellent physician in the community, he has left his memorial on the living institutions of the Medical Center of Delaware and the Henrietta Johnson Medical Center.

In addition to his wife, Emily B., Dr. Morris is survived by his sons, David of Albuquerque NM, Christopher of Northfield VT, Michael of Haddonfield NJ and Dr. Allston Jess Morris III of Newtonville, MA, and seven grandchildren.

Meetings of 1997 of State and New Castle County Medical Alliance

November 16, 1996

9:00 a.m. Medical Society of Delaware Annual Meeting. New Castle County and State Alliance Meeting, DuPont Suite, Hotel DuPont
Representatives from Roth's, Biden's and Castle's offices will debate health care legislation.

* Winter Dinner Dance Pending *

January 23, 1997 Luncheon Trip to Legislative Hall, Dover
To meet legislators and observe the legislature in session.

April 9, 1997 Trip to Washington
9:30 a.m. Business meeting on the train.
11:30 a.m. Meetings with our Senators and Representative followed by lunch.

April 30, 1997 Annual County & State Meeting at the Sheraton, Dover.
11:00 a.m. Business meeting and speakers followed by lunch.

Check the meetings that you wish to attend and return this form to:

Medical Society of Delaware Alliance
1925 Lovering Avenue
Wilmington, DE 19806

- ☐ November 16 — Annual Meeting
- ☐ January 23 — Trip to Dover
- ☐ April 9 — Trip to Washington
- ☐ April 30 — Annual Meeting at Sheraton, Dover

OBITUARIES

Warren R. Johnson Born 1931
Lynn, Massachusetts. Died August 1996.
Graduate of Colby College, Maine and Yale
Medical School 1957. Internship and resi-
dency in Pediatrics at Delaware Hospital,
Wilmington. Board certified in Pediatrics
1963. He took additional training in Pedi-
atrics at Johns Hopkins Hospital in the 1960s
and in the psychiatric aspects of pediatrics in
the 1970s. He had an active practice of pedi-
atrics in Wilmington beginning in 1961, and
was an energetic participant in the medical
society and the pediatric department begin-
ning in the early 1960s. He directed the edu-
cational and residency training programs in
pediatrics at the Medical Center since 1980.
He involved in the affairs of the community,
in the care of the poor and homeless in the
1970s. He is survived by his wife Suzanne,
two sons, a daughter, two step-daughters and
a stepson. There are three grandchildren.

Joseph F. Hughes Born 11/21/08
in Jersey City, New Jersey and died 9/1/96 in
Honolulu, HI. He received his MD from
Jefferson 1935, interned at Cooper Hospital,
Camden NJ and practiced general medicine in
Woodbury, NJ until 1942. From 1942-45 he
served in the Army, and on his return started
a preceptorship in surgery which lasted 7
years. During most of that time he also
worked as an instructor in Anatomy at
Jefferson. He then took 2 years of formal resi-
dency in Surgery (1 year Chief) at what is
now the Medical Center of Delaware. The fol-
lowing year he took his examinations and was

certified by the American Board of Surgery.
Thereafter he was elected a Fellow of the
American College of Surgeons. He practiced
General Surgery in Wilmington 1954-79 when
he moved to Honolulu, HI to accept a position
in Disability Evaluation with the Veterans
Administration Regional Office there.

Dr. Hughes was a man of wide ranging
interests and abilities. He was at different
times President of the Gloucester County (NJ)
Medical Society, the Surgical Staff at one of
the hospitals of the Medical Center of Dela-
ware, and at St. Francis Hospital,
Wilmington. He was instrumental in the
founding and early direction of the Blood
Bank of Delaware, the Kidney Foundation of
Delaware and the first renal dialysis center in
Delaware. He established a research founda-
tion in memory of his eldest son who died fol-
lowing an accident in 1956. He is survived by
his wife Mary and three other children, four
grandchildren and three great-grandchildren.

Harold P. Sortman Born 5/22/10 in
Wilmington, died 12/7/94. He received his MD
from Jefferson in 1936 and took internship at
Delaware Hospital, Wilmington and Beebe
Hospital, Lewes, Delaware. He did family
practice in Wilmington until 1942 when he
entered the Army. He was assigned to the fa-
mous First Division and saw action as a Bat-
talion Surgeon in North Africa, the invasion
of Sicily, the primary assault on Omaha
Beach on D Day. (See *Del Med Jrl*, June
1994, Vol 66, No 6, pp 329-331) and the cam-
paign through Europe into Germany. He re-

ceived the Bronze Star, the Silver Star (for outstanding bravery under fire) and the Purple Heart (he continued to work in spite of the wound). Following the war he returned to his private practice in Wilmington and continued to distinguish himself the rest of his life in his service to the people of Wilmington, by his gentle, caring and kindly nature, his calm and reassuring manner and his ability to impart this tranquility to his patients. At the time of his retirement in 1990, he was awarded The Order of the First State by Governor Castle in recognition of his services to the people of Delaware, and received a letter of commendation from Senator Biden. His wife, Pearl, died in 1990. He is survived by two daughters, a son and eight grandchildren.

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OF LOCAL INTEREST

New Law Reconfirms Jefferson Medical College as Delaware's Medical School

A Delaware bill signed into law in July by Gov. Carper reconfirms the role of Jefferson Medical College (JMC) of Thomas Jefferson University in the medical education and health care of the state of Delaware.

Through the Delaware Institute of Medical Education and Research (DIMER), also reauthorized by the new law, an arrangement between the State and Jefferson reserves admission for students from Delaware each year to JMC. According to the law, this arrangement is "extremely valuable to the State and has produced benefits which far surpass the admission of at least 20 Delaware residents into Jefferson each year."

"Jefferson is quite appreciative of being named state medical school of Delaware," says Joseph Rodgers MD, associate dean of residency and affiliated hospital programs at JMC. "Many Jefferson students receive their clinical training from Delaware physicians at the Medical Center of Delaware, Wilmington Veterans Medical Center and the duPont Hospital for Children. It has been a long and fruitful association for us."

The arrangement between the State and Jefferson has been in place since 1970, a year after DIMER was created to provide greater medical education opportunities for Delaware residents. In lieu of funding and maintaining a medical school, the State developed "a coordinated program of premedical, medical and graduate education among state public institutions of higher learning, Delaware hospitals and Jefferson Medical College." The current

law reorganizes DIMER and expands its responsibilities in order to better serve the state of Delaware.

Delaware Health Plan Consortium Acquired by MCD Health Services

Health care reform has been and will continue to be the topic of national discussion and debate. However, even before all the national focus on health care issues, the Medical Society of Delaware was working with Delaware's major insurers and hospitals to answer the needs of the uninsured. As a result of these efforts a low cost plan with a rich benefit structure emerged and was specifically designed to meet the needs of Delaware's uninsured. With the help of the Delaware Health Care Commission and the Welfare Foundation a not-for-profit organization was formed to market this insurance product.

This non-profit health services organization is the Delaware Health Plan Consortium which was established in 1994. The special benefit program created at that time and which continues today is Basic-Care 1000. With this plan, health care coverage became an affordable option for small businesses which otherwise would not be able to afford coverage for their employees.

In August of 1996 The Delaware Health Plan Consortium was acquired by MCD Health Services Corporation. Under this new arrangement the Consortium will become a wholly owned subsidiary of MCD Health Services Corporation and maintain its status as a non-profit organization along with its commitment to providing low-cost health insurance

to Delaware's working uninsured. The acquisition will result in a change of assumption of insurance risk to a larger pool of individuals and reduce already low administrative costs even further. With these changes Delaware Health Plan Consortium will continue making an impact on Delaware's uninsured problem.

Physicians Win Anti-trust Relief

On August 28, the federal government released new guidelines for physician networks (i.e., IPAs) that include anti-trust relief.

The new guidelines issued by the U.S. Department of Justice and the Federal Trade Commission will make it easier for physicians to establish fee-for-service networks.

Physician networks now will be analyzed under the "rule of reason." Networks, therefore, will not be viewed as automatically illegal if the physicians' integration through the networks is likely to produce significant effi-

ciencies that benefit consumers and if any agreements on price by the network physicians are "reasonably necessary to realize those efficiencies."

The guidelines state, however, that physician networks whose purpose or effect is to prevent or impede competition are not likely to produce significant pro-competitive efficiencies and, therefore, the price agreements of these networks are illegal.

The guidelines also make it clear that physician networks in which physicians share substantial financial risk will be viewed as reasonable if they are non-exclusive and are not anti-competitive on balance, even if they contain more than 30 percent of the physicians in a market. The guidelines note that the Justice Department and Federal Trade Commission have approved many non-exclusive physician networks that have considerably more than 30 percent of a market's physicians in the network.



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IN BRIEF

Mental Health Symposium To Be Held In January

The Mental Health Association in Delaware is hosting a symposium entitled, "The Total Cost of Illness", focusing on what happens to physical health costs when mental health disorders are untreated or undertreated. The symposium will be held on January 10, 1997 at the Hotel DuPont, Wilmington, DE from 8:00 a.m. to 11:00 a.m. A full breakfast will be served.

The target audience will include State of Delaware senators and representatives, CEO's from major work organizations in Delaware, members of the Medical Society of Delaware, and members of the Delaware Worksite Leadership Council on Mental Health. Issues to be addressed include: the relationship between physical health and mental health; the co-occurrence of physical and mental health disorders; a model corporate health care plan that provides access to appropriate physical and mental health care, without increase in cost; results of a study on the relationship between corporate climate and health costs.

Lewis B. Flinn Library Extends Invitation

You are invited to visit the home page of The Delaware Academy of Medicine at [Http://www.delamed.org](http://www.delamed.org). You will find information on the history of the Academy, the Lewis B. Flinn Library and all its services, the Consumer Library and Tel-Med. For more information, e-mail Lisa DeVuono at ldv@delamed.org

34th Annual Infectious Disease Symposium

The 34th Annual Infectious Disease Symposium, sponsored by the Medical Society of Delaware and hosted by the Medical Center of Delaware and the Delaware Academy of Medicine, will be held May 6th through the 8th, 1997. For more information contact William J. Holloway MD, Director of Infectious Diseases, Medical Center of Delaware, 501 West 14th Street, Wilmington, Delaware 19899. Or call (302)428-2744.



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BOOK REVIEWS

A New Mind-Set for a New Era, A Physician's Commentary on the Health Care Crisis and Society, By Malcolm S.M. Watts MD, Vantage Press, NY, NY, 1995, 105 pp., \$12.95.

Dr. Watts is an internist, a medical editor, and a prize winning medical writer. When I started to read his little book, I thought I was going to find another detailed plan on how to reform health care. Instead, the whole book is a philosophical discussion of the author's view of what historically has been wrong with health care, how it got that way, what our true goals should be, and how all of us need "a new mind set," as the title says, to understand the required goals for a health care system.

He writes of the upheavals in medicine since the advent of Medicare and Medicaid in 1965, of the good those programs do, but of their inadequacy in leaving huge numbers of uninsured and underinsured, of the problems of AIDS, of violence, of smoking, of alcoholism and auto deaths, of guns, of unhealthy lifestyles, of the dangers of the population explosion worldwide, of the shortage of medical generalists and the surplus of specialists and subspecialists, and of the soaring of practice costs to keep up with the flood of paperwork demanded by third parties. He accepts the definition of the World Health Organization that "Health is a state of complete physical, mental, and social well being, and not merely the absence of disease and infirmity."

Dr. Watts concludes that the present health care crisis is a part of the overall societal problem and that a new mind set with new value judgements is needed to put less emphasis on treating diseases and more on improving the health and well-being of humans and of our planet, with less competition and confrontation and more coordination and cooperation.

This is a tall order.

David Platt MD

Putting Health Care on the National Agenda, by Arnold Birenbaum MD, Praeger Publishing Co., Westport, CT, 1995, 228 pp., paper back \$18.95, hardcover \$59.95.

This is an update, to the end of 1994, of a previous book by Dr. Birenbaum who is professor of pediatrics at Albert Einstein College of Medicine. He is a health care policy analyst and researcher and has written this book to help the lay reader understand why the health care system of the U.S. is in serious trouble, and what he thinks should be done to remedy it. He lists some of the major problems as AIDS, loss of insurance coverage with the ever growing number of uninsured, worry regarding medical indebtedness, unnecessary physician initiated services, and businesses burdened by coverage of medical expenses. He emphasizes that expenses must be lowered and that full medical care must be universally available.

Voluntary not-for-profit hospitals are in trouble, because of the shift to outpatient care

and of competition from well financed investor owned hospitals. Two thirds of uninsured people are full time workers and their dependents. There are many workers who make too little to be able to afford the insurance premiums.

Dr. Birenbaum contends that the Clinton health proposal was blocked by organized opponents of reform who in 1994 spent \$1,360,000 in contributions to legislators. His recommended solution is a national health plan which will provide comprehensive care to everyone for everything, including AIDS, and including long-term care and prescriptions. This will be financed by a combination of payroll taxes, taxes raised by the state, and a progressive federal income tax. Patients will have free choice of physicians, hospitals, and other health agencies. Over-utilization by hospitals will be controlled by a global budget, by physicians by peer review, and by patients by a system of deductibles and co-pay (with fees for the poor to be paid by government). A fee schedule for physicians will be negotiated by the state medical societies, with periodic updates. Administrative costs will be kept to a minimum with no claim forms, no billing, and no prior authorization of services. Malpractice costs will decrease, because incidence will be lowered by a better peer review system, and because awards will no longer have to include medical expenses. All professional decisions will be made by physicians and other providers. No one will ever be impoverished to pay for health care, or be left to go without it. Dr. Birenbaum says an organized national system such as here proposed will provide universal comprehensive care including prevention to everyone equally, and at a cost no greater than what is now being spent in this country for care, which is superb for some and disgracefully inadequate for others.

This book can be ordered on a credit card by a phone call to 800-225-5800.

David Platt MD

Gero-Ethics, A New Vision of Growing Old in America, by Gerald A. Larue, Prometheus Books, Buffalo, New York, 1992, 267 pp.

The author is Emeritus Professor of Religion and Gerontology at the Andrus Center, University of California at Los Angeles. This whole book is a thoughtful essay concerning the growing problems of elders. Dr. Andrus starts with the premise that the ethical quality of a nation is judged by the way in which it treats its helpless, its handicapped and its aged. "A good government," he says, "provides a social system that assures all individuals a sense of personal worth — for whatever they are able to contribute to society." His concern is raising of consciousness regarding gero-ethics both today and for the future when the proportion of seniors doubles and triples. Here are some of the 20 chapter headings: human rights of elders; ethics of survival; does the individual belong to God, government, industry, family or self?; elder abuse; aging and the search for meaning — through offspring, through service; longevity; coping with disabilities; love and sex in the elderly; dementing illness; elder isolation and loneliness; elder dying.

Dr. Larue sums up that the result of our having been here alive should have an impact of our presence expressed in concern for the future of our species and of the planet. He says that we should leave the world a better place, that we should live to fulfill our own lives and the lives of others, both here now and to come in the future.

At least we can try.

David Platt MD

Life After Medical School, by Leonard Laster MD, WW Norton, New York, NY, 1996, 344 pp., \$27.50

Dr. Laster is Professor of Medicine and Health Policy and Chancellor Emeritus of the University of Massachusetts Medical Center. Throughout his professional life he has been involved in advising young people contemplating medicine as a career, and has for many years served on medical school admission committees.

Dr. Laster leads off with his personal opinion regarding medicine as a career,

"Medicine is not just a job by which to earn a living; it is a way of life. You would do well to enter it guided by a lasting faith in the joy of life, in the value of compassion, or in the importance of service to others — A good doctor must be far more than a bioscientific technician — A physician should be a caring friend to his patients willing to cope with their personal afflictions and occasional hardships and catastrophes of daily living."

The remainder of this book then consists of personal life history vignettes of thirty-two men and women physicians in which each describes how he or she picked medicine as a career, how hurdles in college, medical school, or residency were handled, how each picked a primary care or specialty path, and how sometimes was impelled to change that path abruptly. The stories are real and compelling. Their choices range from that of a rural family practice through clinical or research physicians in most of the specialties, to academia, to the head of the Robert Wood Johnson Foundation, to the CEO of Merck Pharmaceutical Corporation, and to the editor of the *New England Journal of Medicine*.

If I have to make a criticism of this excellent book, it is that most of the thirty-two physicians who tell their stories are super achievers who reached positions at the very top of their fields. I wish Dr. Laster had included more ordinary mortals.

This is a great book to recommend to anyone thinking about a career in medicine. Becoming a doctor is still very special. As Dr. Laster says, "You should not permit the turbulence of these times to overshadow the spiritual and intellectual attributes of life as a doctor. These will endure — you will be engaged in caring for anxious human beings."

David Platt MD

Reminiscing, My Life in Medicine. A. Henry Clagett Jr., MD. Desktop Published (Available at Ninth Street Bookshop, Wilm., DE), 1996, \$19.95 (cost price), 250 pp.

This is the intensely personal autobiography of our own Dr. Henry Clagett. He was the son of a physician and knew from early childhood

that he would be a doctor.

The book is not a literary masterpiece, but throughout its pages makes the reader think, "That is the kind of doctor we need now!" Dr. Clagett is often gruff and outspoken. He does not suffer fools easily, and speaks in these pages frankly about some he met both in and out of medicine. Through the numerous patient encounters he describes, emerges the portrait of a doctor who had not only a comprehensive knowledge of his field of cardiology and the ability to analyze clinical problems accurately, but of one who so very easily and naturally formed warm human bonds with his patients.

The book starts with vignettes of the author's family and childhood, his medical student days, at Hahnemann, and his internship at Homeopathic Hospital (later Memorial), including tales of his relationship with patients and staff.

An interesting chapter describes in clinical and human terms his subsequent year, at the request of his father, as a country doctor in Milton (population 1500) in Sussex County, where house calls brought \$1.00, if the patient had it. Then followed a D.Sci. in internal medicine at University of Pennsylvania Graduate School of Medicine and a cardiology fellowship at the Heart Station of Rhode Island Hospital.

Next came military service, first at Walter Reed and Tilton General Hospitals, then as chief of cardiology at the army's 1000 bed 90th general hospital in France. His war time stories are replete with penetrating tales of the military people he treated, usually with expertise, always with devotion.

Back home in civilian practice, Dr. Clagett's personal story becomes a virtual comprehensive history of the development of modern cardiology, especially fascinating because it is personalized.

An interesting aside, a long chapter details the author's love of woodworking and is complete with photos of the cabinets, bookcases, etc., which he created.

Throughout the book Dr. Clagett comes across as a man who is sometimes opinionated, sometimes gruff, but always intellectually honest, always interested primarily in the

welfare of his patients, who often became his friends.

The book ends on a sad note when the author is wondering whether medicine is slowly becoming a business. If young doctors will take time to read this rough gem, more of them may be turned in the right direction.

David Platt MD

Moral Matters, Ethical Issues in Medicine and the Life Sciences, by Arthur Caplan PhD, John Wiley & Sons, New York, 1995, 198 pp.

Dr. Caplan is Professor of Bio-Ethics at the University of Pennsylvania Medical School. This book is a compilation of essays which started as installments of his column on ethics in a daily newspaper. The author does not write of ethics theory. Instead he states the clinical and sociological facts of a specific case, then proceeds to discuss the background and alternative solutions, by the way illustrating the ethical concepts involved.

From his preface, "This book is supposed to make you think. If you are willing to spend your time reading this slowly, so closely that you find flaws and mistakes in my reasoning, then they are serving their purpose."

"Ethics is not the same as morals. Morals refer to what people believe about right and wrong, good and bad, virtue and vice. — But to do ethics, you must be willing to do more than simply share your opinion about what is right or wrong, good or bad. You must be prepared to back up your opinions with argument."

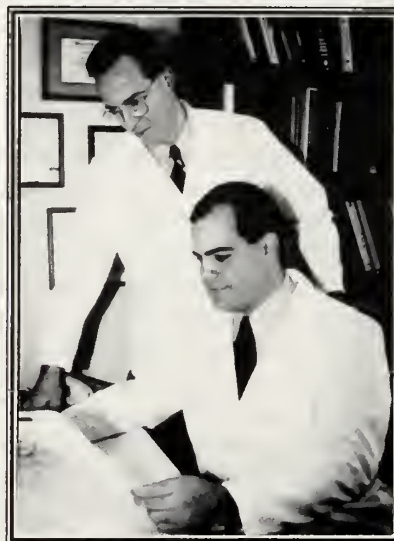
The cases of each chapter illuminate a current problem of our society. Some of them are: contraception and abortion, infertility and technological reproduction, right to refuse medical treatment, euthanasia and the right to die, AIDS, genetic manipulation, organ transplantation and the rationing of scarce medical resources, and human experimentation.

This book does make the reader think.

David Platt MD

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MSD MONTHLY ACTIVITIES

Working for You: September 1996

Leadership Activities

- Mark Meister and Bob Rock met to discuss status of Delaware Health Plans Consortium.
- Mr. Meister, Beverly Dieffenbach, Virginia Collier MD and Murray Kopelow MD (of the Accreditation Council of Continuing Medical Education) met via a conference call to discuss changes in ACCME guidelines.
- Mr. Meister and Mr. Reed of Blue Cross Blue Shield of Delaware met with representatives of Avicenna Company to discuss intranet technology.
- Mr. Meister attended the Pfizer State Leadership Council
- AMA Trustee Dr. Lewers, Carol A. Tavani MD and Mr. Meister met with Robert A. Doughty MD to discuss membership program for A.I. duPont Institute physicians.

Physicians' Advocate Program Activities

- Presented a free workshop designed to help physicians with their negotiating skills. Over 60 physicians and staff members attended this program, presented in September at the University & Whist Club.
- Provided on-site consultation services on management and accounts receivable evaluation, following up each consultation with a written report outlining observations and recommendations.

- Helped several new physicians in establishing their practices, providing such services as carrier credentialing and hiring office staff.
- Provided medical practice with inservice designed to sharpen an office's efficiency.

CREDENTIALING CONNECTION Activities

- Received 35 phone calls from physicians regarding CREDENTIALING CONNECTION services.
- Began receiving enrollments/applications from physicians.
- Total of 37 contacts made at MCOs and hospitals via telephone.
- Received 4 phone calls from physicians who want to hold off joining until MCO/hospital contracts are signed.
- Hired new full-time employee as Credentialing Coordinator.
- Attended DMGMA Annual Dinner meeting.

Continuing Medical Education Activities

- Sponsored 15 educational activities for Category 1 credit.

Major Meetings

- Physicians Health Committee met
- Medical Care Advisory Committee met
- Maternal & Child Care Committee meeting
- Committee on Aging met
- Delaware Medical Education Foundation Committee met

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INFORMATION FOR ADVERTISERS

The *Delaware Medical Journal* is a monthly publication of the Medical Society of Delaware. The *Journal* reaches approximately 75 percent of the state's physicians, as well as medical libraries, and hospitals; its circulation is approximately 1,600.

Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting.

Closing for space reservations is the first of the month, two months prior to publication. Closing for materials is the first of the month, one month prior to publication.

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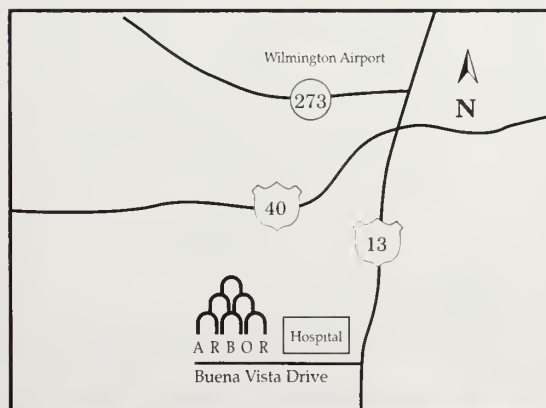
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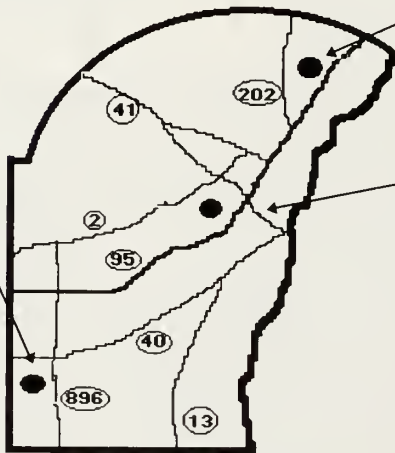
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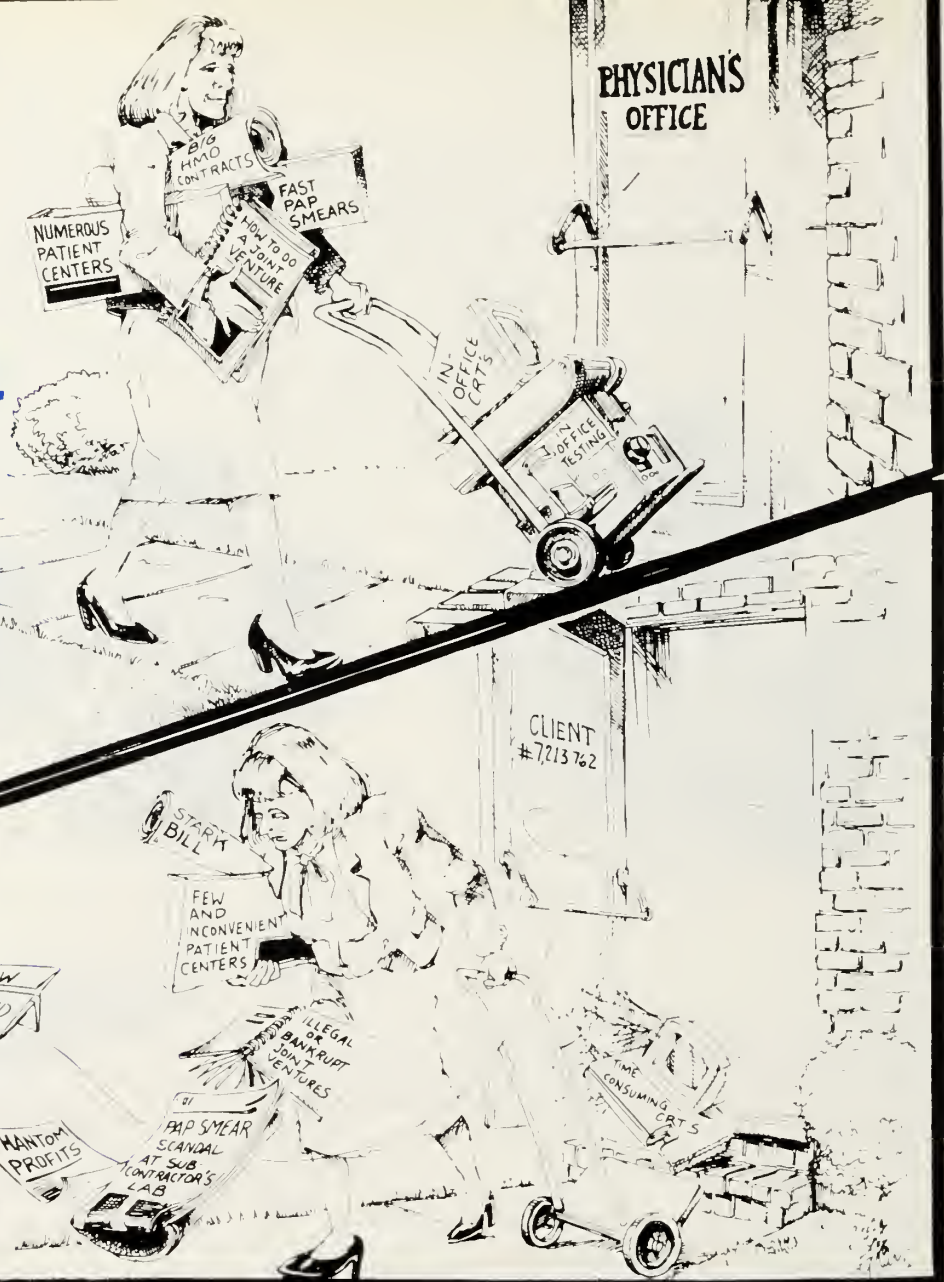
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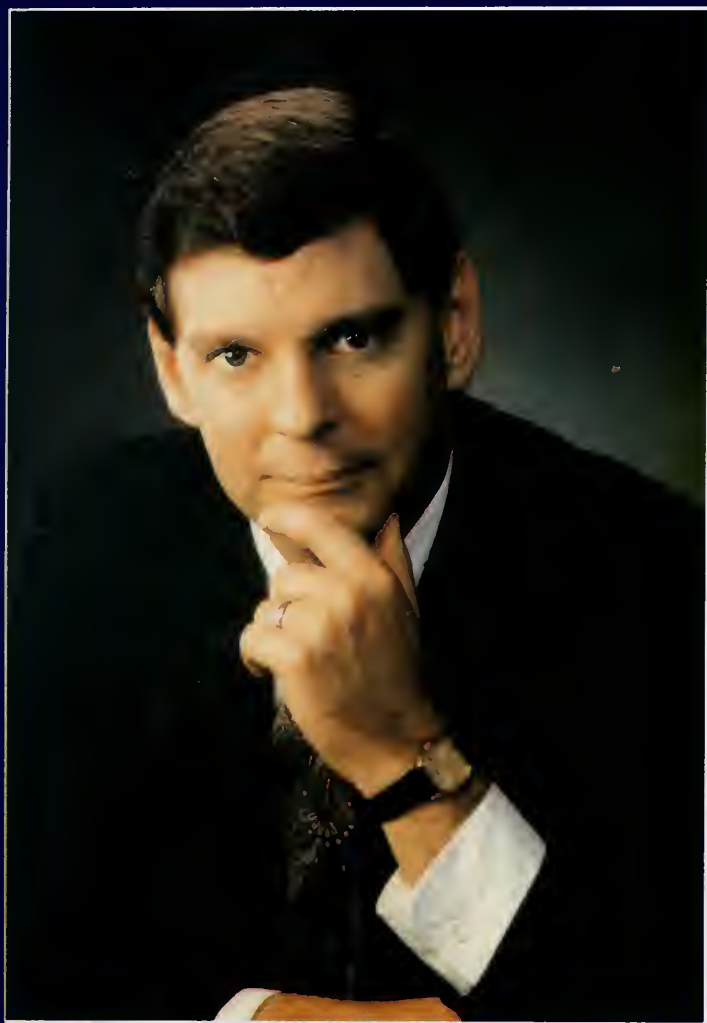
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Inaugural Address

The following is Society President Dr. Paul E. Howard's inaugural address, given Saturday, November 16, 1996.

Thank you, Madam President, Mr. Speaker, Trustees and Delegates. I stand before you today somewhat nervous, not only because I am not blessed with remarkable oratory gifts, but more so, because I am keenly aware of the tremendous honor you bestow and trust you display in asking me to serve in this capacity. I thank you for this and will make every effort to prove that your trust is as well placed as it has been with preceding presidents.

Please keep in mind in judging my efforts that I am following a succession of very tough acts. We are privileged as an organization in having a tradition of energetic, insightful, imaginative, diligent, and self-sacrificing leaders. It is, in fact, difficult to decide where to end such a list of adjectives in describing the men and, finally, women who have served in this position. Certainly all of these adjectives describe our out-going president, Dr. Carol Tavani. I ask you to join me in thanking her for her tireless efforts on behalf of the Medical Society. On a more personal note, I would like to thank her for affording what is for me, perhaps, a once-in-a-lifetime opportunity of coming before a group to speak and finding that the microphone is actually too low for me. (That's right, Carol — one parting shot about altitude.)

Even zealous presidents rarely, if ever, accomplish much independently. They require a great deal of help to fulfill their missions. This assistance comes not only from our exceptional staff, but also from our members, especially each of you and the others who ac-

cepted the calls to leadership as trustees, delegates, county society officers, and committee chairs and members. This need will always be there; I know that each of you will continue to answer these calls to leadership in order to keep our society a viable organization of genuine value to physicians and patients.

To achieve this end we must continue to be imaginative, offering innovative, proactive services of palpable worth. These include the likes of the contract review and the wide array of other valuable services available through the *Physicians' Advocate* office. They also include the more recently unveiled Society subsidiary, the Credentialing Connection, formed with the intent of reducing the hassles involved in multiple credentialing and recredentialing processes, and another newly formed subsidiary — the Medical Network Management Services of Delaware, Inc., or Med-Net.

Med-Net has, to me, obvious potential to rival in importance our now well-established subsidiary, MSDIS, which has proven its worth to individual physicians, physician groups, and the society at large, time and time again. Med-Net's charge, if you will, is well summed-up in its letterhead which reads: 1) "enabling physicians to lead," and 2) "empowering physicians to serve."

We all know that there are cataclysmic changes occurring in our healthcare delivery systems. Because we have had very little control over or input into the nature and scope of these changes, we have come to view change as something inherently negative. It is not. Given the present costs of delivering care in our existing systems, significant changes are, in any case, inevitable. These changes can oc-

cur to the benefit of both patients and providers (who, let's not forget, are also patients with families comprised of more patients), but only if physicians are allowed to take meaningful roles in shaping and directing these changes, and in the ongoing governance of the new systems put in place. Med-Net has been established for the sole purpose of providing mechanisms whereby this can happen. I urge each of you to give this service due consideration and to encourage your colleagues within your medical communities to do the same.

These efforts carry with them obvious financial implications for physicians. They also carry equally important implications regarding the ways in which we will be allowed to practice medicine in the future. For instance, who will making the necessary decisions regarding credentialing standards, quality assurance standards, utilization standards, etc.? Physicians cannot and should not be mere cogs in an impersonal, rigid, and often misdirected healthcare machine. This is not what you want; this is not what your patients want; this is not what our communities want, or need. This is what we will get if prevailing trends are allowed to "run their courses."

We are quickly heading towards a point where the financial bottom line becomes the primary deciding factor in virtually all medical decisions. The error in this direction is self-evident. Furthermore, let's ask ourselves who benefits from improvements in this bottom line: physicians, patients, hospitals, employers? I believe the answer to this question should be, E — all of the above. Instead, we are often finding forced upon us another answer, F — none of the above. I believe that Med-Net affords our members their best opportunity to reverse these trends.

Of course, such efforts run the risk of being labeled as wholly self-serving. They are not. These claims will come essentially from three flanks. First will be those who have vested interests in preventing physician empowerment. Second will be those who have personal axes to grind. We can't do much about either of these groups, other than to put on the gloves and slug it out. Finally we will be dealing with the much larger group, those who, frankly, know very little about physicians on a personal level. This group represents fertile ground for planting educational

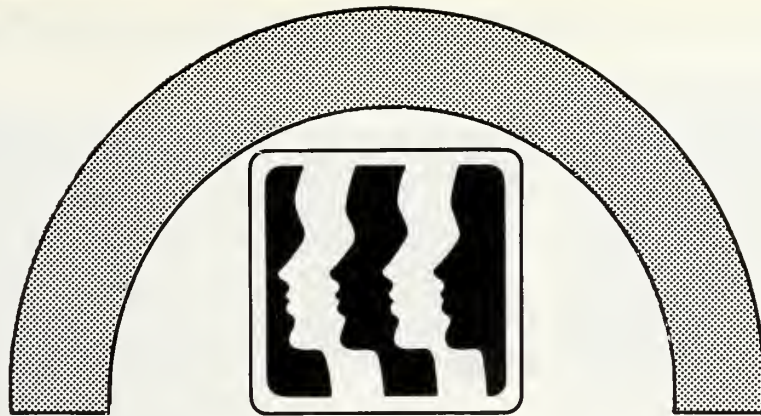
seeds which may blossom in such a way as to eventually restore much of what has been gradually sapped from the practice of medicine in America.

It is difficult to define just what it is that has been lost, but if forced to be concise I suppose that I would say that the practice of medicine has been stripped of much of its spirituality. Perhaps this is a reflection of the changes in our society at large, as we have become more impersonal, cynical and litigious. In any event, there are those who would transform or reduce the doctor-patient relationship to a detached unadorned business relationship between supplier and consumer. This will not meet the needs of the doctor or the patient. I suggest that we would all be well served by frank public dialogue on this and other such issues. I believe that the public has had very little unbiased exposure to the views of physicians and organized medicine on such issues. I further believe that it is largely our fault. We need to take this bull by the horns and make our positions more widely known. In not doing so we will allow others to claim the title of patient advocate and to cast physicians in any light they find to be to their particular advantage. If, on the other hand, we do so, patients will recognize that our goals converge with their goals, and they will recognize that physicians are still, just as in the days of Galen, the ultimate patients' advocates. If the coming year produces any legacies, I certainly hope that among them are the beginnings of effective and perpetual mechanisms facilitating this dialogue.

In closing, please allow me to repeat that I am truly honored by your call to service. As some of you know, my father and grandfather were physicians. So, I grew up with physicians. I must tell you that, in spite of this familiarity, I grew up pretty much in awe of doctors. Yet, my appreciation for the people in our profession has only grown over the years. This esteemed organization asking me to serve in this way is sincerely humbling. I will try to be up to the task. Once again, I thank you.



Paul E. Howard MD



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Entering the "Land of the 'puter braindead"!

Ernest S. Campbell MD



We talked about "Surfin' the Internet" previously and I have had several requests to be somewhat more specific and try to reach the "Land of the 'puter braindead"! Well, having been dead

and brought slowly back to life myself, here goes another try at transmogri-fication.

The Internet is a global network of computers that communicate using a common language. When you connect to a "browser" such as Netscape, Internet Explorer, Mosaic or any of the browsers used by online services (America Online, Prodigy, Compuserve or the MSN web sites), you are connected to the Internet. A "browser" is a software tool that you use to look at web pages. This software can usually be found on the Internet free for the downloading. ("Downloading" means transferring from one computer to another.) The Internet is similar to the international telephone system — no one owns or controls the whole thing, but it is connected in a way that makes it work like one big network.

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About forty million people have Internet access today. The World Wide Web (the web or WWW) gives you a graphical, easy-to-navigate connection for looking at documents on the Internet. These documents, as well as the links between them, comprise a "spider web" of information.

The web lets you jump or "hyperlink" from one web page to other pages on the web. You can think of the web as a big library. Web sites are like the books, and web "pages" are like specific pages in the books. Pages can contain news, images, movies, sounds, radio, telephone, 3D worlds — just about anything. These pages can be located on computers anywhere in the world. When you are connected to the web, you have equal access to information worldwide; there are no additional long-distance charges or restrictions.

The World Wide Web is changing the way people communicate all over the globe. This new global medium is gaining popular acceptance faster than any other communications medium in history. Over the last two years, the web has grown to include a vast array of information — everything from stock quotes to job opportunities, bulletin boards to news, previews of movies, literary reviews, and games. The type of information ranges from the most obscure to the most globally important. People often talk about "surfing" the web and visiting new sites. "Surfing" means following hyperlinks to pages with subjects you may never have heard about, meeting new people, visiting new places, and learning about things from all over the world.

Remember, the Internet is not just about corporate or scientific information. Because it

is very easy to publish on the web, many individuals have set up personal "home pages," pages about themselves and their interests, pictures of themselves, and more. My own "home page" is served by Gulf Telephone out of Foley, Alabama, but I'm able to add and delete items from my personal computer, updating it on a regular basis. This information is available to anybody in the world who has web access.

A "home page" is the starting point for a web site. It is something like the cover page or the Table of Contents of a book. Each web page, including a web site's home page, has a unique address called a Universal Resource Locator (URL). My page's address is "http://www.gulftel.com/~scubadoc/". Pages on the web are interconnected. You connect to other pages by clicking text or graphics that are called hyperlinks. Hyperlinks are underlined or bordered words and graphics that have web addresses (also known as a URL — Universal Resource Locator) embedded in them. By clicking a hyperlink, you jump to a particular page in a particular web site. You can easily identify a hyperlink. Hyperlink text is a different color from the rest of the text in a particular web site. Surfing the web means following hyperlinks to different web pages. As you surf around the web, you may find pages you have read about or seen mentioned on television.

Using the Browser to Look at Information

If you have gotten this far in your interest in the Internet, you probably have an online access and can access the Internet on your PC. If this is the case, you are looking at the page on the Internet with a web browser. Just like any other software, a browser is just a tool, a special tool used for navigating and accessing information on the web. The browser's toolbar (a row of icons across the top of the page) shows the controls for navigating the web and managing the information you find there. The toolbar provides a range of detailed functions and commands for managing the browser. The address bar below the toolbar displays the current web site address being accessed. To go to a new web site, you type the site's web address (URL) directly into the white

space on this bar. When you're finished typing, press Enter on your keyboard. Each web browser has some useful buttons on its toolbar, allowing access to features unique to itself, such as search engines and its own homepage and links.

Certain navigational features are common to all browsers:

- 1) Back and forward buttons. The Back button returns you back to a previously displayed page, usually the most recent page. The Forward button returns you ahead to a previously displayed page. If you have not used the Back button in a current session, the Forward button will be inactive.
- 2) Open Start Page Button. The Open Start Page button returns you to your default start page. The start page is the page that you begin on when you open your browser.
- 3) Browser Logo. The "Browser" logo in the upper right corner of your screen moves as your browser accesses or downloads information. If the icon is moving for longer than you would like, use the Stop button described below.
- 4) Search Button. The Search button opens a page that contains Internet Search tools, such as Alta Vista, Yahoo, Lycos, Incite, Savvy Search, and Infoseek.
- 5) Stop Button. The Stop Button immediately stops the browser from accessing a link.
- 6) Open and Add Bookmarks or Favorites. You can tell your browser to remember web pages that you would like to visit again by adding them to your bookmarks. You can always go back to any of these pages by using the bookmarks or favorites list. You can even organize your bookmarks into folders.

Doctors are by nature impatient and don't care to wait for a slow computer. That's why I suggested previously that you get the best equipment possible so that you won't be put off by long downloading waits (transferral of data from another computer to yours).

Internet servers allow many people to access a page at the same time. But not all servers are equal, and some may not be able to keep up with the demands of many people's browser requests. If it seems to be taking a

long time to load a page, be patient. It's not unusual for a page to take a while to access. If you try to access a page and see a dialog box that says it's unavailable or busy, treat it just like the busy signal on a telephone and try again later. Go on to something else on the Web.

Modem speed does make a difference; for surfing the web, you will want to use a modem that runs at a speed of at least 14.4 Kbps. The faster your modem, the less time it takes to load graphics and the more interactive the session can be. A 28.8 Kbps is more than twice as fast as a 14.4. The larger the file, the longer it will take to download to your browser. If you find yourself getting frustrated by slow connections, get a faster modem. It will improve the quality of your web surfing experience.

If the "moving" logo in the upper right corner of your browser toolbar is active for an unusually long time (longer than the time it takes to get a cup of coffee and return to your computer), use the Stop button to halt your

request. There is a rule of thumb for how long a page will take to download; it all depends on the speed of your modem, but in general, with a modem running at 14.4 Kbps it takes about 1 second to download every Kbyte of information. A 30-Kbyte file will take about 30 seconds.

Summary

My goal has been to give you a basic understanding of the concepts involved with understanding and exploring the web. By this point you should know: what the Internet is, what the World Wide Web is, what a web site is, what a home page is, what a URL is, what a browser is, what hyperlinks are, and how to use your browser to surf the web. Problems that arise can usually be solved by going to the "Help" icon on your browser or going to the Web Tutorials that all browsers have on their software.



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It has been some time since we've launched ourselves on the Internet or made any changes to this page — our apologies, but we are still novices in this technology. We intend to update our information much more frequently as we become more conversant with the HTML language. From this web site, our members and others who browse the Net can access a wide array of on line resources helpful to physicians and allied health professionals. To access the information that interests you, simply click on the icons below.

We hope you find the newly updated information useful and are enjoying MSDNet. If you have any comments, questions or suggestions, please let us know via [e-mail](#).

From the Desk of Carol A. Tavani, M.D.

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The Internet's Role in CME

Timothy Brigham PhD

I have been involved in education for a number of years but it is only recently that I have become a convert to computer-based learning (CBL) and the Internet. Although I once saw CBL as mildly interesting and a nice teaching tool, I now consider it an essential tool in graduate and continuing medical education. The Internet has become a vast distribution network for information of all kinds and CME is going to be a part of it.

As a practical example, scheduling traditional CME for residents has proven difficult. Each residency has numerous existing time commitments and clinical emergencies. Schedules vary from one residency program to another. And, residents who are away on rotation at one of our affiliates face even more difficulties once you add in travel time. We simply can not afford to put on these programs over and over! It is clear that we need a different delivery mode for our instruction.

From an educational perspective, I believe we need to shift from a teacher-centered to a learner-centered environment. Teacher-centered programs focus on delivering the same content to a group of people at a set time. A learner-centered approach addresses the fact that learners may have unique learning needs, unique learning styles, and perhaps, different locations.

To be learner-centered, programs must be flexible and be deliverable in multiple formats. This is where I think computer-based learning via the Internet will play a significant role. If a resident or practicing physician

can't attend a class at the time it is offered, he/she will be able to log in over a network and get access to a computer-based version of the program.

Internet-based CBL gives us more than just improved teaching methods. It will allow us to improve evaluation and needs assessment. Evaluation will be more efficient as we track what people are learning and how well. Monitoring the types of CBL most accessed will help determine needs assessment. The number of times a program is accessed is automatically counted by the system, giving us instant statistics on the type and subject matter of the CBL being used. This feedback will help us determine which subjects to focus new development on as well as which types of CBL program are preferred.

Dr. Frisby's article on the Internet is a good primer for getting started. The number of web sites containing information relevant to medical practitioners continues to grow in both quantity and quality. I am sure you will find the Internet-based materials useful and informative.

The Internet and Medical Education

Anthony J. Frisby PhD

Abstract

The Internet is a watershed event. Access to information resources throughout the world has never been greater or easier. The Internet's effect on medicine, education and practice, is being expanded and redefined daily. Understanding what the Internet is and how it is effecting medical education and medical practice will be vital to the successful practitioner. This paper will provide historical information on the development of the Internet and define the current terminology used by computer professionals and the media. It will discuss how the Internet is currently being used and why you want to be a part of it.

Introduction

A common language is required for successful communication to take place. When you hear or read reports in the news media, technical terminology and jargon are frequently employed to lend credibility to the author. However, new terms must be created to define new concepts and materials which previously did not exist. Recognizing this need for new terminology can quickly take the mystique out of any otherwise unknown entity — and the Internet is no exception.

So just what is the Internet? Simply put, a collection of computers and computer networks linked together and sharing a common communication protocol — in this case IP or Internet Protocol. You may have a local area network (LAN) already in your practice. The Internet is a collection of thousands of local area networks and wide area networks (WAN) connecting to each other. With a connection to the Internet, a message from my computer here in Philadelphia, can wind its way through the many different connections and networks to a colleague in Romania. In fact, I can send much more than a simple note. I can

send an entire multimedia program to him, or make it available for everyone to access, but more on that later.

Okay, you may be thinking, I can picture this huge network connecting computers throughout the world. But what good is it? Why would I use it? Information. The Internet provides access to information in support of educational (new and continuing), medical practice (treatment guidelines, drug dosing, legal changes, etc.) and patient education.

History

Medical colleges were actually early developers of computer-based learning (CBL). Some institutions, like the Ohio State University began creating CBL in the 1970s. They did not catch on big at first, perhaps due to the highly graphical nature of medicine. Advances that allowed educators to include graphics, animation and sounds came to authoring languages in the late 1980s through early 1990s. At about this time, Tim Berners-Lee, a researcher at the European Laboratory for Particle Physics, CERN, began working on a computer program that would allow fellow researchers to share common documents, complete with illustrations and reference materials. He used a simple markup language that would format the document for on-screen viewing so researchers would not have to print each document. These researchers were all using UNIX workstations so they had a common platform that would write, edit and view these documents.

Researchers at the National Center for Super-computer Applications (CSA) in Illinois noticed this program and decided to develop a way for microcomputers to be able to view these documents. They released their viewer, Mosaic, in 1993. Using Mosaic, both Macintosh and Windows users could access

these files and view them without the need for sophisticated UNIX workstations. The language used to create the documents became known as HyperText Markup Language (HTML).

HyperText because the language allowed for simple linking to other documents (or images, sounds, and movies). Markup Language because the programming code required only simple commands around the text you wanted to format. Shortly after NCSA released Mosaic, competing versions of HTML viewers hit the market. Currently the most used application to view HTML files is Netscape.

HTML viewers, like Netscape, were able to view not only files on the local computer or local area network, but anywhere on the Internet. A new term, the World Wide Web (WWW) or simply the web, was coined to describe how pervasive HTML was becoming. Applications like Netscape became known as World Wide Web browsers because anyone having the application could "browse" the Internet looking for information in the form of text, images, sounds or even movies.

Education

Thomas Jefferson University (TJU), like a few other key research universities around the country, was quick to see the potential the World Wide Web had for distributing information. At a time when many schools were still struggling with ways to create educational materials that both Macintosh and Windows users could share, TJU's Academic Information Services and Research (AISR) group was developing interactive, multimedia course materials for the basic science curriculum. In 1994 AISR developed JEFFLINE, a campus-wide information system, on the World Wide Web. Using a virtual office as a visual metaphor, users were able to quickly navigate throughout the online information system. Many faculty in the medical school saw the World Wide Web as an ideal vehicle for delivering information about a course. Announcements, updates and changes to the syllabus can easily be made and instantly available to the students.

Since that time, nearly every course at TJU has what is now known as a "homepage."

A page on JEFFLINE links information about the course, faculty, syllabus, computer-based learning materials, practice exam questions and just about every other course related item you can imagine. Departments at many other medical colleges have course homepages and CBL as well. Computer-based learning, now via the Internet, is becoming a common educational tool for today's medical students.

Medical education on the web is not limited to only medical students. Continuing Medical Education (CME) is becoming available online and the web is likely to become a widespread distribution vehicle. Like videotapes, CME on the web is available when it's convenient to your schedule. It does not require traveling or interrupting your patient schedule. You can take it at your own pace and wherever is convenient for you - provided that you have a computer and access to the Internet!

Next time you have access to the web, try to search for your alma mater. It's very likely to have a homepage. You may also want to search for some of the professional societies you belong to — more of these are "going online" every day. Both groups may even have CME available to you. If not yet, it's likely they will soon! At the end of this paper are Internet addresses, known as URLs (universal resource locator) for some of the most popular medical related sights.

Medical Practice

Professional societies from a wide variety of disciplines are creating web sites for their members to access and to increase public awareness. The American Medical Association's (AMA) web site has a wide range of information useful for the medical professional. Information on educational opportunities, changes in healthcare reform, announcements of new drug studies and more are available from the AMA's homepage. Discipline specific societies like the American Society for Colposcopy and Cervical Pathology (ASCCP) and the American Society for Clinical Pharmacology and Therapeutics (ASCPT) have web sites. Some societies have restricted forums that only members can access. There they can discuss unusual cases with their col-

leagues online. Professional newsletters and journals are being added to websites where members can search through back issues for topics that may now have renewed importance to them. Online publishing of journals, sometimes nicknamed e-journals or e-zines (for electronic magazine), are able to significantly reduce the delay in getting important research and clinical findings to the practitioner. Many journals have a publication delay of more than six months. Long delays in new treatments can have tragic and unnecessary effects on patients.

The National Institute of Health and the National Library of Medicine both have web sites dedicated to getting important healthcare and treatment information to practitioners in a timely fashion. General practitioners as well as researchers and academic professionals access these web sites to analyze treatment options and apply them to new situations. Information on applying for grants and getting involved with clinical trials are more examples of the type of online information you may access.

The AMA and other healthcare groups are actively involved in the healthcare reform issues currently being addressed by the federal and state governments. Following these changes in the media can be very time consuming. Using the Internet, you can find out what your professional society is doing to protect both your interests and to ensure your patients continue to receive proper medical attention.

The Internet is a powerful communications tool. In addition to the important practice effects already mentioned, the Internet can be used to find out information on new drug treatments, results of clinical trials, dosing information, toxicology and more. Pharmaceutical companies have web sites that do more than just promote their products. They provide clinical research results, dosing information and poison treatment alerts. Online databases offer access to clinical monographs written by colleagues, potential teratology risks, treatment indications, and precautions. As an easy to use tool to access information, the Internet has no equal.

Patient Education

Perhaps one of the most interesting areas to arise on the Internet is that of patient education. Information from national societies, healthcare institutions, and insurance providers have grown on the web. Community support groups, like an Alzheimer's support group on the Cleveland Freenet, were started. This group was a prototype to see if people caring for a family member suffering from Alzheimer's would use the Internet based support group. The response was both touching and overwhelming. Accounts of people logging on during the night discussing fears and doubts were met by others with words of encouragement and support. Those who had already experienced the progression of the disease were able to turn this devastating pain into advice and support for others.

Web sites specializing in such areas as women's health have appeared. These sites offer educational and support materials written by and for women. Practitioners know that patients sometimes hold back questions they may have out of fear or embarrassment. Patients are much more open about discussing their problems, fears and concerns online. The access to helpful information that may answer their questions, or calm their anxiety has made patient education sites very popular on the web.

One of the very best I've seen is KidsHealth.org A web site that is focused on providing healthcare information to kids, their parents, and their doctors. The site is full of graphics to keep the kids interested. The language used is appropriate depending on the section you are in — kids, parents or practitioner. Parents can find information about childhood diseases, care, and support. Practitioners can get tips on how to treat kids, and address their special needs. Sites like this demonstrate the tremendous impact the Internet can have.

Conclusion

This paper is by no means a complete analysis of the valuable materials available on the Internet. No such volume could ever be created as the Internet is a dynamic, constantly growing database. What I hope to have ac-

complished was to define some of the terminology you have likely seen and may have not understood. The opportunities the Internet offers to you as a medical professional are hopefully apparent. It's been said by some that the problem with the Internet is not in the lack of information available, but that there is too much. The word infoglut has been used to describe the information overload felt by some people when they access the Internet. There is no doubt that there is more information there than anyone could ever read. However, if there is one thing that medical informatics has taught us, it's that knowing everything is not possible, but knowing how to find out is. The Internet is becoming the delivery vehicle for that information. Why is the Internet important to you? Information.

List of sites:

Medical Education

Thomas Jefferson University's JEFFLINE
<http://jeffline.tju.edu/>

The American Medical Association
<http://www.ama-assn.org/>

The National Institutes of Health
<http://www.nih.gov/>

The National Library of Medicine
<http://www.nlm.gov/>

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FAQ — Frequently Asked Questions

Ernest S. Campbell MD

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How can I use my computer to get CME? There are several ways that the computer can be helpful in obtaining CME credits. In addition to providing lists of up coming CME locations, it can offer sources for books, audio tapes and syllabi for accredited CME material. Quite a few CM ROM sources are available but can be expensive.

Just now beginning to come online are free or inexpensive online services that will probably grow by leaps and bounds. Using forms and online questions, the exams are electronically graded and the CME credit is returned. To keep up-to-date on these sources-just use one of the search engines, type in "online CME" and follow through with your choices returned.

I did that with my Internet Explorer and came out with the following web sites:
<http://www.cme-1.med.ohio-state.edu/>
 (Here you can get CME for credit and non-credit)

http://www.cmea.com/(CD ROMs with Category 1 and 2 credits)

http://www.cmeweb.com/(AMA Category 1, AAFP, ACEP, AAP approved. Requires registering and small fee for testing online)

http://www.ama-assn.org/cgi-bin/cme-redir (AMA CME locator, 2000 AMA PRA category 1 sites)

http://text.nlm.nih.gov/nih/cdc/cme/index.html (Free CME quizzes)

http://bio-3.bsd.uchicago.edu/Hhs/Lead/Lead-toxicity.html (free CME on lead poisoning)

http://medicus.marshall.edu/medicus.htm (Marshall University Interactive Patient WEB, small charge of \$15).

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Medical Resources on the World Wide Web (WWW)

Stanley R. Platman MD

Imagine that from your desk, you could do the following:

- consult with peers and worldwide experts on any clinical problem at the click of a mouse;
- send a draft of a paper to coauthors and receive back the changed document the same day;
- read as many journals as you wish without paying a single subscription charge;
- brush up on your continuing medical education in almost any medical area;
- receive a DNA sequence file on the day of its publication;
- browse through a bookshop's catalogue, order and pay for your favorite textbook;
- obtain an immediate updated bibliography on almost any subject.

Such an environment already exists: the Internet, or in the language of the press, the "information superhighway." Some view the Internet as a place of unbounded potential; others find it a seductive waste of time. Many physicians see the Internet as unfamiliar territory, with strange customs and jargon. However, for all medical practitioners, whatever their speciality, the benefits offered by Internet are growing rapidly while the costs to use it and the time to access a wealth of information are shrinking.

Not so long ago, the "newbie" had to master the arcane intricacies of UNIX, a powerful but unfriendly operating system. Now, within minutes, you can "surf the net" just by clicking on your mouse button.

What is the Internet?

Telecommunications networks began with electronic computer-to-computer correspondence among scientists. In the early 1980s, networks began forming among academic institutions. One of the first systems, Bitnet (Because It's Time Network), linked institutions that granted degrees. Bitnet was handicapped because the government agencies and industry were not represented. Internet then evolved, representing a "meta-network" — a network of networks. It provided a way of joining many diverse networks, including those of governments and very recently industry.

The Internet, the largest global computer network in the world, consists of many computers, a set of physical (or wireless) links between these computers, and a set of rules or protocols governing the exchange of information between the computers. Almost any computer can connect to it and exchange information with millions of other connected computers across the world. The number connecting to just one component of the Internet, the World Wide Web has increased more than thirty-fold in just one year, so that over thirty million people currently use the Internet.

Connecting to the Internet

Three levels of Internet access include

1. Electronic mail (E-mail), which connects from a machine outside the Internet but

still in the matrix, gives access to most Internet services, albeit in a rather clumsy manner.

2. A "shell account," the most basic connection, establishes a real time interactive connection between your computer and another machine that is permanently connected to the Internet. Your computer does not become part of the Internet proper, but you can use the connection to gain text only access to most Internet services.
3. To gain full access you need software to handle the TCP/IP (transmission control protocol/Internet protocol). Many companies and universities provide dial up access, usually charging a connect fee and a monthly subscription charge based on hours used on line. As most of these entities have "points of presence" throughout the country, you can usually access them by a local phone call. Your computer will require a modem for this access and the company will provide you software allowing access to its computer "home page." From this home page, you can surf the net.

More recently, many commercial online services, including America Online, CompuServe, and Prodigy, have started providing connections to the Internet, including the Web.

Once connected, you can surf the net, download from almost any site, access a world wide web page in Singapore or send an E-Mail anywhere in the world for no charge other than the monthly subscription fee.

Although there is no charge for moving information over the net, users are bound by an informal code of conduct, often termed "netiquette." For example, netiquette expects that you will not retrieve locally available files from distant sources. Netiquette forbids posting unsolicited advertising to multiple recipients (a practice known as "spamming").

Using the World Wide Web

Among the many ways of communicating on the net, E-Mail, telenet, file transfer protocol, network news, gopher and the World Wide

Web, the Web provides the most recent and user friendly way of exchanging, manipulating and publishing information. The Web, a subset of the Internet, refers to areas that use a common collection of protocols and standards providing a pleasantly visual medium to enjoy the Internet. Fortunately a variety of search techniques can help you find suitable sites for your specific interest, because the medical presence on the Web has grown far too large for you to survey unassisted.

Web sites (home pages)

In 1989 Tim Berners Lee and other researchers at the CERN, the European Particle Physics Laboratory in Geneva, Switzerland, developed the Web for researchers. Web sites, often called home pages, are the basic unit of information on the Web. Each home page has its own address configured so that anyone with a Web browser can view the content of the site. Four elements needed for creation, transmission, or retrieval of home pages include

- Hypertext, uniform resource locators (URL),
- Hypertext transfer protocol (http), and
- Hypertext markup language (html).

Hypertext underpins the Web. The term, coined by Ted Nelson in the sixties and later incorporated into the Macintosh program HyperCard, now is also featured in the "help" program built into the Windows operating system. In its most basic form, hypertext functions like an electronic footnoting system in which a hypertext link takes you to more detailed information about the issue in question. However, hypertext links on the Web, unlike conventional footnotes, may lead you to information held anywhere on the Internet, in another town or country or even on another continent, and the information you receive may be in text, graphics, a sound file, or even a movie. Hypertext links can be embedded within any part of a Web page and are not necessarily arranged in a hierarchical format. How hypertext links are highlighted varies according to the Web browser — most browsers use underlining or display text in a different color.

Uniform resource locators (URL) are the standard form of address used in hypertext links to retrieve or send information. You can use them not only to access other Web pages but also to interact with other Internet services, such as gopher, file transfer protocol, or E-mail. Most URLs contain three pieces of information: the service ("the protocol"); the Internet address or host name of the server; and the filepath to follow to access a specified file on that server. The format is typically: `PROTOCOL://SERVER-NAME/PATH`.

You can use a URL in three ways to take you somewhere on the Web. First, you can simply click on a hypertext link on a Web page. In this case, the URL, buried inside the link, is invisible to you, the user. Second, you can supply your Web browser with the URL by typing it manually. Use this option if you find a URL for an interesting site printed in a magazine, journal, or book. Finally, if you are using a suitable operating system you can cut and paste a URL, from an electronic document (such as an E-mail message) into a window on your Web browser.

Hypertext transfer protocol (http) is used to transfer information on the Web. An http connection lasts just long enough for you to request and a server to send a Web page or image. Because you need a separate connection to retrieve each image on a Web page, displaying pages with graphics can be very time consuming. The Web browser Netscape speeds things up by running multiple connections in parallel when accessing such pages.

Web pages are plain text documents, marked up in hypertext markup language (html), which defines the format of areas of text by tagging them. A Web browser interprets the tags so that tagged areas are displayed differently from the normal style of text. The manner of display varies from browser to browser.

Among the Web browsers available for almost all operating systems, the simplest, such as Lynx, allow users with text only Internet access to explore the Web (albeit missing out on its graphic richness). NCSA Mosaic, the first widely used Web browser that not only displayed in line images but also provided ac-

cess to gopher and other non-Web Internet resources, revolutionized the Web; however, Netscape Navigator has now replaced it as the most commonly used Web browser.

Accessing medical resources

For a step-by-step example of how to use the Web, imagine that you plan to give a lecture on Attention Deficit Disorder (ADD). To access information relating to the subject, you can use two approaches. First, start your search at the site called Yahoo (your home page probably has the URL for this popular site). Click onto Yahoo and from its home page select the link to Health and then the link to Mental Health. From the list of mental health options, select Attention Deficit Disorder; click onto one or several choices from the number of options listed relating to ADD. For example, if you click on Attention Deficit Disorder Archive, it will take you to its home page from which you can make a series of further choices. You will find an extraordinary amount of information available; surplus is a common problem.

As an alternative approach to finding this information on the Web, you can use one of the "search engines" that collect and index data published on the Web. Lycos, one of the most comprehensive of these, currently holds information over five million Web pages. When you enter Attention Deficit Disorder, it will show a listing of various potential sites to use. Once you have found an interesting site on the Web, you can easily revisit it by using your history list (temporary) or bookmark list (permanent).

Potential problems

Although in the future, many physicians will search the Internet in the same way they now turn to their textbooks and journals, others will continue to feel ambivalence about using it.

Some physicians see a potential danger in the Internet as patients can access information often not accessed by members of the medical profession. Just as physicians can surf the net, patients can now

- Obtain professional and lay support with-

out leaving their home, a huge plus for those who are acutely ill or incapacitated;

- Easily contact fellow sufferers anywhere in the world at any time;
- Collect information, post questions, and seek advice about topics they would be too embarrassed to raise with their physician face to face;
- Retrieve information instantaneously, a particularly important ability in the face of a life-threatening medical condition;
- Explore a great number of resources quickly and easily by using the links on Web sites.

Armed with knowledge gleaned from the Internet and online services, more and more patients demand that they, too, have a hand on the tiller when physicians, insurers, and other players set a course of treatment for them. As Joseph Zebley, M.D., noted in the October 23, 1995, *Baltimore Sun*, "People will come in with anecdotal reports of untried regimens...Very often the physician has no idea what they are talking about."

In spite of this potential problem, of the initial phobia that many feel when first approaching the information highway, and what you may have read about pornography and other distractions, the Web continues to offer literally thousands of connections to useful medical resources

As the *British Medical Journal* noted in its editorial of May 27, 1985, when it became the first general medical journal to launch itself into cyberspace, "[the] consequences may be as far reaching as the introduction of the penny post."



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The Human Side of the Internet

To better understand how the Internet affects human interaction, *Delaware Medical Journal* talked with Keith Duncan, president of DCANet (a division of Consult Dynamics, Inc.). DCANet is the service provider for the Medical Society and members who subscribe to the Society's MSDNet service.

Delaware Medical Journal: Let's start by giving our readers some background information.

Keith Duncan: I founded Consult Dynamics while I was a graduate at the University of Pennsylvania. CDI was originally oriented towards research consulting in the area of technology integration; however, when I graduated with my PhD in 1992, I realized that there were not that many job opportunities in my academia field, so I decided to pursue my business full time. It was at this time that I decided to focus on wide area networking (WAN) and the Internet.

DMJ: Was your degree in computer science?

KD: No, it was in an interdisciplinary program that focused on sociology, conflict, economics, and language. My doctoral research analyzed the problem of how to make their jobs easier or more productive. At the same time, it looked at the kinds of conflicts that technology created within the workplace.

DMJ: So, unlike many in the computer industry, you have not only the technical expertise, but also the human side.

KD: Well, I think that it is always important to keep in mind that technology *should* be designed to help people. In a broader sense, it is people that make the Internet such an interesting force. The

technology itself is affecting people's work and social behavior, but what is so fascinating is how people then are creative with these tools.

DMJ: Can you offer a definition of the Internet?

KD: The Internet is a physical network of dedicated cables that connect computers around the world together. The amazing thing about this physical network of wires and machines is that they all can talk to each other. This is made possible by the set of rules that govern the way data can be sent across this physical network. These rules are known as TCP/IP.

DMJ: Which means ...?

KD: The metaphor of an information superhighway has been used very frequently in describing the Internet. Although this has become somewhat of a cliché, I think it is an apt characterization. The Internet is appropriately thought of as the physical "highway" over which the data travels.

DMJ: Can you explain the relation between DCANet and the Internet?

KD: Sure. DCANet was formed to serve an emerging market that wanted to be able to use the Internet. We sell access to the network to individuals and companies. When you want to "surf the 'Net," you just log on; DCANet takes care of all the technical details that make the connection possible. We are what is known as an online service provider.

DMJ: Can you talk a little about the human side of the Internet?

KD: I view the Internet as a social phenomenon -- one that will change human interaction. For years,

the Internet was only seen as a research and educational network. You could find the information you needed for a particular project, whether directly from the source or from someone using the 'Net. From its beginning more than 20 years ago, the culture of the Internet was based on the sharing of information.

Now, as more people use online services, social behavior and patterns of interacting and communicating must be modified to accommodate the restrictions of the online forum.

DMJ: In what way?

KD: The anonymity and inability to monitor body language while on the 'Net can lead to exaggerated behavior. Eye contact, body movement, tone of voice, the physical space in which people interact and communicate all are additive to the actual verbal communication. When you remove these "cues," if you will, it becomes necessary to develop ways to compensate — by exaggerating one's behavior, for example. In some ways this loss of visual and auditory identity while on the 'Net is liberating.

DMJ: Can you give an example?

KD: Well, I've spoken to many women who have found that gender-related differences are not an issue on the Internet, especially if the woman has a name that is not obviously female. Likewise, other factors that differentiate us visually from one another — color, handicap or age, for example — are also negated on the 'Net.

DMJ: In what way is this type of anonymity negative?

KD: Things that are difficult to say face to face can be easily typed and sent via e-mail with little discomfort. While this would be positive in the case of, say, sharing honest information in a performance evaluation, it would be troubling if used to fire employees.

DMJ: This has been done?

KD: Yes, there are stories of this happening.

DMJ: Can you offer your view of the Internet and medicine?

KD: The world is clearly moving online, raising some interesting questions about how these online services may benefit medical information and

interactions. Clearly, many physicians, hospitals, and medical schools have invested in the new Internet technologies. It is becoming a standard that hospitals and large medical groups will, indeed must, have a web site. Just how successful these sites are and what information they should publish is not yet clear.

Arguments can be made on both sides of the fence in terms of the value of publishing such information. The key challenge is going to be struggling with the questions of how the use of online technologies might help the medical profession reduce the cost of providing health care. If it cannot be shown that there are economies of scale and cost savings in publishing medical information or in conducting medical interactions, then this technology will not be widely adopted by the medical community. If, however, there are creative solutions to some problems in these areas, then its impact could be enormous.

If you'd like information about MSDNet, the Medical Society's Internet service, call the MSD office to request an MSDNet brochure and application for a dial-up account (connection to the 'Net).

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SURFING THE INTERNET WITH MSDNET

... Introducing Your Connection to the World

In the fall of 1995, the Medical Society stepped into the future of communications by launching its own home page and e-mail on the Internet. Now you can ride the crest of this exciting new wave of information technology by coming online with MSDNet.

MSDNet is a way physicians can interact with other physicians, the Medical Society, colleagues across the country and even around the world. **MSDNet** provides on-line access to:

- ✓ **Member Matters:** Meeting notices, calendar of events, practice management information, current publications at a glance, and much more
- ✓ **Legislative and Regulatory Issues:** State and federal issues of interest to physicians
- ✓ **Medical Resources and Research:** A listing of libraries, clinical databases, hospitals and other helpful resources
- ✓ **E-Mail:** Send mail to the Society staff and officers
- ✓ **World Wide Web:** **MSDNet** provides direct access to the Internet and World Wide Web

MSDNet is made possible through an arrangement with DCANet, a division of Consult Dynamics, Inc., a Wilmington-based firm specializing in Internet access.

Q AND A ABOUT MSDNET

What's a quick definition of the term "Internet"?

In a nutshell, the Internet is a collection of interconnected networks.

Who's on the Internet?

There are nearly 5 million computers linked to the Internet today, and the current number of users — 30 million worldwide — is projected to grow to 100 million within five years.

And I'd want to get on the 'Net because ...?

If being able to consult with experts in your field quickly, being able to research the latest literature about a particular case, and being able to leave messages for Society staff and/or officers — all when it's convenient for you, without interrupting patient care — appeals to you, you'd want to look into getting on the 'Net.

Why should I subscribe to MSDNet?

Because unlike other commercial services, its costs are fixed. There's a one-time nominal set-up fee and a low monthly fee. For that monthly fee, you'll be able to spend 90 hours online. This is a value you will find absolutely nowhere else — and such an outstanding value is being offered only to members of the Medical Society of Delaware.

What equipment will I need to have or obtain to be able to take advantage of this benefit?

You'll need a computer that has Windows or Macintosh software. The Internet program will run as well as the software does; that is, if you're using

a 386 and Windows is sluggish, so will the Internet functions be. It is recommended that your computer "platform" be a 486/33 minimum, with 4 megs or, even better, 8 megs.

Is a computer all I'll need?

Almost. You'll also need proprietary software, which will be provided by DCANet as part of the initial setup. You'll also need a phone line, either one to be used exclusively by the computer or one that you won't mind being in tied up while you're online. Last, you'll need a modem, either an internal or an external one. The rule of thumb here is "the faster the better" — a minimum of 9600 baud is recommended. So all you'll need are 1) a computer, 2) the software, 3) a phone line, and 4) a modem.

I've been told by my computer firm that I can't alter the software on my system in any way or my contract with them will be void. Does this mean I can't take advantage of the MSD web site?

Not necessarily. The software DCANet will provide for your system should not impinge on the other software on your system in any way, so there should be no problem with your computer support firm. If you have any concerns, you should investigate this by contacting your software vendor or DCANet before proceeding.

Am I going to have to do any sort of maintenance?

The software might need to be upgraded at some time in the future, but nothing other than that. If an upgrade is necessary, you will be provided with clear instructions on how to install it.

What is it going to cost for me to get onto the Internet and use it? What's the bottom line?

As you'll see on the accompanying application, DCANet will charge a nominal one-time fee to set up your system. Each month, you will pay a set, low fee, which entitles you to 90 hours of on-line time during that month. If by some chance your office actually uses that amount of online time and you'll exceed this "allotment," then you will be charged \$2 per hour for each hour over 90. It might be helpful to compare this to what two of the top Internet service providers offer: \$9.95 per month for five hours per month; additional hours are billed at \$2.95 per hour. Industry statistics show that average users spend 15 hours online each month — that's \$40.

Is this like using the telephone, where prime time costs an arm and a leg and the off hours are late at night or very early in the morning?

Not at all. This is a flat fee arrangement — 90 hours a month for the set monthly fee. Plus, your dialup to the Internet is a local call, even in Kent and Sussex Counties.

How will I know how much time I'm using?

Although it is extremely unlikely you'll reach the 90-hour-a-month limit, you can monitor your online usage by simply sending e-mail to hours@dca.net.

Am I going to need training to use this software?

No. It will be set up in such a way that you'll be able to access the MSD web site quickly and easily. If you want to "surf the 'Net," you may or may not need some training, depending on your experience and comfort with using a computer. DCANet will be providing a special, free clinic for MSD members who feel this will be helpful for them. MSD may develop additional special materials or training sessions for its members if there is enough interest in them.

Will someone on the 'Net be able to breach the security of my data files?

This is virtually impossible. The way things will be set up, no one will be able to "get into" your computer and review your data files. The only time your files might be at risk would be if you downloaded (copied into your system) software that performs a function (as opposed to a file of information). Sometimes a computer virus is put into these "executable" (software that performs a function) files so that when you instruct it to act, the virus goes into action. There are, however, many different software packages that detect and neutralize computer viruses.

I understand MSD's web site will be a way for me to access information at other web sites. If this is the case, then why don't I just get on the Internet and "drive the superhighway" myself?

If you're comfortable using your computer, there's no reason why you can't. However, what MSD's site will do is provide up-to-the-minute information about MSD and issues of interest to Delaware physicians. In addition, it will have grouped together many other different web sites for you to

explore with just a few keystrokes. You can certainly access them on your own, but tracking down the addresses of various libraries, medical facilities and the like can be a time-consuming process. With MSD's web site, we'll have most of the ones you'll want to access right at your fingertips.

Well, what if I'm already hooked up to the Internet? Can I access the MSD web site?

Certainly. It makes no difference whether your access is provided by DCA, Prodigy, America Online, or someone else. You can access our site no matter who your provider is.

Is there any way I can have my own web site?

Yes, there is. While not for everyone, establishing a web site on the Internet can be an effective way to educate your patients and inform your colleagues about your practice. The fee for establishing a basic, entry-level home page — approximately two 8½" x 11" pages of content — includes a one-time setup fee of \$100 (includes turning the content into html and scanning of one image to be used as a graphic) and a monthly fee of \$22.50.

Will MSD have information about Society activities on its web site?

Absolutely! **MSDNet** will be updated to incorporate breaking news as it happens so that you'll have the information you'll need when you'll need it. This method of communication with our members will allow timely communication to a degree never before possible — not with any of our publications or phone-calling or faxing marathons. It will be like having an MSD staff member in your office at all times.

I'm a member on a few of the Society's committees. Will there be a way for me to respond to meeting notices or for me to leave messages for the staff?

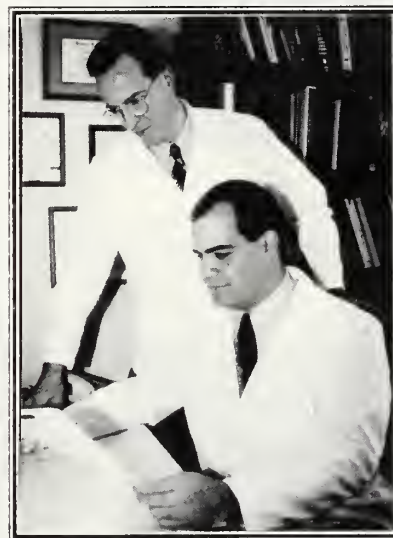
Yes. You will have the ability to leave messages in the general e-mail "box" or in the confidential e-mail "box." General messages will be picked up and routed to the appropriate staff members. Confidential mail will be picked up only by Mark Meister.

Who do I call if I have questions?

If you have questions about the information provided by **MSDNet**, call the MSD office at (302) 658-7596 or (800) 348-6800. Of course you can e-mail us at info-msd@medsocdel.org. If you have questions about the software, hardware or other technical aspects, call DCANet at (302) 654-1019 or e-mail at info@dca.net.

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OF INTEREST

Internet Addresses

General Medical

American Academy of Pediatrics
<http://www.aap.org>

AMA
<http://www.ama-assn.org>

American J of Nursing
<http://www.ajn.org/>

American Medical Informatics
<http://amia2.amia.org/>

Anatomy of the Human Body
<http://rpiunl.mda.uth.tmc.edu/>

Anesthesiology & Surgery Center
<http://www-sci.lib.uci.edu/HSG.MedicalSurgery.html>

Arthritis
<http://www.crl.com/~fredt/faqs/FAQ>

Atlantic Reproductive Health Center
<http://www.ivf.com>

Baylor College of Medicine
<http://www.bcm.tmc.edu/>

Biomed
<http://www.cursci.co.uk/BioMed-Net/biomed.html>

BC/BS Mass
<http://www.bcbsma.com>

British Medical J
<http://www.bmj.com/bmj/>

CAM
<http://hwbbbs.gbmg-umc.org>

Cancer
http://www.cancercare.org/faq/cancer_faq.html

Cancer Center/M.D. Anderson
<http://utmdacc.mda.uth.tmc.edu>

Cancer Related Links
<http://dialin.ind.net/~rmarriag/rcancer/html>

CDC
<http://www.cdc.gov>

Census Bureau
<http://www.census.gov/>

Center for Imaging and Pharmaceutical Research
<http://civr-diva.mgh.harvard.edu/>

CIC Health Web
<http://www.ghsl.nwu.edu/>

CliniWeb
<http://www.ohsu.edu/clinweb/>

Clinical Tools
<http://healthguide.com>

Clinical Trials
<http://www.primenet.com/~iwpp/sterling.html>

CMA Online
<http://www.hwc.ca:8400/>

CMIDR AIDS Patents Project
<http://patents.cnidr.org/>

Columbia-Presbyterian Hospital
<http://www.cpmc.columbia.edu/cisdemo>

Community of Science
<http://cos.gdb.org/>

Cyberspace Hospital
<http://ch.nus.sg/>

Decision Support System DXplain
<http://www..les.mgh.harvard.edu/dxplain.htm>

Dental Net
<http://www.pencom.com/dentalweb/>

DHHS
<http://www.os.dhhs.gov>

Disabilities Access
<http://www.pavilion.co.uk/CommonRoom/DisabilitiesAccess/>

Disability Resource
<http://disability.com>

DOIT
<http://weber.u.washington.edu/~doit>

DOT
<http://www.dot.gov>

Duke
<http://dmi-www.mc.duke.edu/>

Electronic Medical Record System
<http://www.medg.lcs.mit.edu>

Family Internet
<http://www.familyinternet.com/medic/htm>

Family Practice Handbook
<http://indy.radiology.uiowa.edu/>

Family Practice Journal
<http://www.phymac.med.wayne.edu/>

Family Practice Residency
<http://weber.u.washington.edu/>

FDA
<http://www.fda.gov>

FedWorld
<http://www.fedworld.gov/health.html>

Foundation for Shared Medical Decision Making
<http://www.dartmouth.edu/dms/cecs/fimdm/>

GenBank
<http://www.ncbi.nlm.nih.gov/>

- GenRx
<http://www.icsi.net/GenRx>
- Global Health Network
<http://www.pitt.edu/home/ghnet/ghnet.html>
- Gold Standard Multimedia Inc.
Home Page for Physicians
http://gasnet.med.nyu.edu/demos/TEE_Tutorial_Description.html
Gold Standard Multimedia Inc.
- Clinical Pharmacology
<http://www.gate.net/~gsm>
- Good Health
<http://www.social.com/health/news.html>
- Graduate Hospital Imaging Center
<http://www.netaxs.com/>
- Hancock's Index of Medical Resources
<http://kuhttp.cc.ukans.edu/cwis/units/medcntr/Lee/HOMEPAGE/HTML>
- Harvard Medical Library
<http://www.med.harvard.edu/>
- HCFA
<http://www.ssa.gov/hcfa/hcfahp2.html>
- Healthcare Events Calendar
<http://www.uthscsa.edu/hostcal.html>
- Health Care Investment Analysts
<http://www.hcia.com/>
- Health Care Liability Alliance
<http://www.wp.com/HCLA/>
- Health Care Professional
<http://www.majors.com>
- Health Education Technology Information
<http://www.web.nlm.gov/>
- Health Info-Com Network Medical Newsletter
<http://cancer.med.upenn.edu:3000/>
- Health Letter on the CDC
<http://ip.holonet.net/homepage/ld.htm>
- Health Libraries
<http://www.arcade.uiowa.edu/hardin-www/hslibs.html>
- Health on the Internet Newsletter
<http://www.pavilion.co.uk/daccess/D-Acess/newsletter/HOT.html>
- Heart Surgery Forum
<http://www.hsforum.com/heartsurgery/homehsf.html>
- Herbs
<http://drum.ncat.edu/~okolo/holistic/herbs.html>
- Herbs for Health
<http://www.wit.com/mirrors/mac/info/nms/>
- Hernia Information Home Page
<http://www.demon.co.uk/herniaInfo/>
- Hershey Medical Center
<http://www.xray.hmc.psu.edu/public/home.html>
- Hiatal Hernias
<http://chorus.rad.ncw.edu/index/3.html>
- Home Page for Physicians
http://gasnet.med.nyu.edu/demos/TEE_Tutorial_Description.html
- HyperDOC
<http://www.nim.nih.gov>
- Hospital Web
<http://demOnmac.mgh.harvard.edu/>
- Image Engine
<http://dublin.smi.med.pitt.edu/>
- Image Guided Surgery J
<http://www.igs.wiley.com>
- Indian Health Services
<http://www.tucson.ihs.gov>
- Interactive Colorado Medical Rounds
<http://medrounds.uchsc.edu/>
- Interactive Health Systems
<http://insite.com>
- Interactive Patient
<http://musom.marshall.edu>
- International Health News
<http://vvv.com/HealthNews/>
- International Travelers Clinic
<http://www.intmed.mcw.edu/travel.html>
- JAMA
<http://www.ama-assn.org/journals/standing/jama/jamahome.htm>
- LARGnet Medical Image Access
<http://johns.largnet.uwo.ca:80/>
- LifeNet
<http://www.owinc.com/partners/bc/compass/lifenet/lifenet.htm>
- Mayo Clinic
<http://www.mayo.edu>
- Medical College of Ohio
<http://www.mco.edu/>
- Medical Education
<http://www.primenet.com/~gwa.med.ed/>
- Medical Education Information Center
<http://medic.med.uth.tmc.edu/>
- Med Help International
<http://medhip.netusa.net/index.htm>
<http://tumpike.net/emporium/c/CAPNET/health1.htm>
- Medical Business Finder
<http://www.firstmark.com>
- Medical Imaging Research
<http://agora.leeds.ac.uk/>
- Medical Librarian
<http://wormhole.map.com/~dkurkul/>
- Medical Matrix
<http://www.siumed.edu/lib/matrix>
- Medical Meeting Place
<http://www.packet.net/medical/Welcome.html>
- Medical Resources
http://planetree1.utmen.edu/Net_Resources/NetResources.html
- Medical School Pages
<http://www.cc.emory.edu/WHSC/medweb.schools.html>
- Medical Specialties
<http://www.primenet.com/~gwa/med.ed.ed/specialties.html>
- Medicine OnLine
<http://www.meds.com>
- Medline
<http://www.sils.umich.edu/~nscherer/Medline/MedlineGuide.html>
- Medlink International
<http://www.medlink.com>
- Mednews
<http://biomed.nus.sg/MEDNEWS/welcome.html>
- Medscape
<http://www.medscape.com>
- Medscrip
<http://www.rust.net/~skindell/medscrip.html>
- MedSearch America
<http://www.medsearch.com9001>
- MEDSTUFF
<http://www.opennet.com/medstuff/welcome.html>
- MedWeb
<http://www.ashe.miami.edu/ab/medweb.html>

- Menopause Matters
<http://world.std.com/~susan207/>
- Merritt, Hawkins & Associates
<http://www.practice-net.com>
- Minnesota Health Data Institute
<http://www.mhdi.com/>
- MMWR
<http://www.crawford.com/cdc/mmwr/-mmwr.html>
- MRI/CTscan
<http://www.ge.com/>
- MRI Group
<http://www.mri.uta.edu>
- Multimedia Medical Reference Library
<http://challenge.tiac.net/>
- National Center for Health Statistics
<http://www.cdc.gov/nchswww/nchshome.htm>
- National Institute of Health
<http://text.nlm.nih.gov/>
<http://helix.nih.gov>
- National Library of Medicine
<http://www.nlm.nih.gov/>
- National Organization of Physicians Who Care
<http://www.pwc.org>
- National University of Singapore
<http://biomed.nus.sg/>
- NCSA
<http://bucky.aa.vic.edu>
- Net Dentist
<http://www.netdentist.com/>
- Neuromuscular Physiology
<http://ortho84-13.ucsd.edu/>
- Neurosciences Internet Guide
<http://http2.sils.umich.edu/Public/nirg/nirgl.html>
- NewsFile
<http://www.newsfile.com/>
- NII Health Award
<http://www.gii-awards.com/health.htm>
- Nurses' Call
<http://www.npl.com/>
- OncoLink
<http://oncolink.upenn.edu/>
- Office of Disease Prevention and Health Promotion
<http://www.os.dhhs.gov:81/PIIP/>
- Online J of Current Clinical Trials
<http://www.ref.ocic.org:2000>
- Online Mendelian Inheritance in Man
<http://gdbwww.gdb.org/omim/docs/omimtop.html>
- OSHA
<http://www.osha.gov>
- Pathology
<http://www.path.usuf2.usuhs.mil/>
- Pathology
<http://fester.his.path.cam.ac.uk/>
- Pharmaceutical Chemistry
<http://www.pharm.ucsf.edu/>
- Pharmaceutical Information Network
<http://phaminfo.com/>
- Pharm Web
<http://sunsite.unc.edu/pwmirror>
- Physicians Guide to the Internet
<http://www.webcom.com/pgi/>
- Physician Online
<http://www.po.com>
- Physicians Who Care
<http://www.pwc.org/>
- PMS, fertility, menopause, osteoporosis
<http://www.polaris.net/health/>
- PracticeNet
<http://www.practice-net.com/>
- Primary Care Internet Guide
<http://www.uib.no/>
- Primary Care Teaching Topics
<http://uhs.bsd.uchicago.edu/>
- Primary Health Care Specialist Group of the British Computer Society
<http://www.ncl.ac.uk/~nphcare/PHCSG/phcsgl.htm>
- Put Prevention into Practice
<http://www.os.dhhs.gov:81/PIIP/>
- Radiology
<http://www.rad.washington.edu/>
- Radiology
<http://www.xray.hmc.psu.edu/>
- Red Cross
<http://www.crossnet.org>
- Rehabilitation Research and Training Center
<http://www.icdi.wvu.edu/Others.htm>
- Richard C. Bowyer's Home Page
<http://www.wp.com/bowyer/>
- Roxane Pain Institute
<http://www.roxane.com/>
- RSNA
<http://www.rsna.org>
- Science
<http://www.aaas.org/>
- Simone Protective Pharmaceuticals
http://128.138.129.27/health/cancer/simone_prot.html
- Sleep Medicine
<http://www.cloud9.net/>
- Stanford
<http://medwww.Stanford.EDU:80/Med Center/>
- Subhas Roy
<http://www.cs.wm.edu/~subhas/health.html>
- TALARIA
<http://www.stat.washington.edu/TALARIA/TALARIA.html>
- Telemedicine
<http://www.arentfox.com/>
- Toxic Substances and Disease Registry
<http://atsdrl.atsdr.cdc.gov>
- Trauma Net
<http://www.trauma.lsumc.edu>
- University of Virginia
<http://www.med.virginia.edu:80/>
- Virtual Medical Center
<http://www-sci.lib.uci.edu/HSG/Medical.htm/>
- Virtual Hospital
<http://indy.radiology.uiowa.edu/VirtualHospital.html/>
- Virtual Library of Medicine
<http://golgi.harvard.edu/biopages/medicine.html>
- Visible Embryo
<http://visembryo.ucsf.edu/>
- Visible Man
http://www.nlm.nih.gov/extramural_research.dir/visible_human.html
- Dr. Wasserman's Parent Page
<http://www.gate.net/~lewis/parents.html>
- WebPath
<http://www-medlib.med.utah.edu/>
- Wellness Letter
<http://www.dc.ewnews.com/magazines/ucbwl/>
- What's New at SilverPlatter World
<http://www.silverplatter.com/SP-NEW.HTML>
- Whole Brain Atlas

[http://count51.med.harvard.edu/Women's Health Hot Line Newsletter](http://count51.med.harvard.edu/Women's%20Health%20Hot%20Line%20Newsletter)
<http://www.soft-design.com/softinfo/womens-health.html>

World Information Networks Corp
<http://www.fest.com/>
<http://www.insilico.com/>

Yahoo
<http://www.yahoo.com/Health/Medicine>

Mental Health

AA Web Site
<http://www.moscow.com/Resources/SelfHelp/AA/>

Access to Sleep and Psychology
<http://web.sjsu.edu/~hawkins>

ADD
<http://www.seas.upenn.edu/~mengwong/add/>

Administrators in Academic Psychiatry
<http://www.umdj.edu/~pulieml/AAP.home.htm/>

Alfred Adler Institute of San Francisco
<http://ourworld.compuserve.com/homepages/hstein>

Alzheimer's Association
<http://www.alz.org>

American Academy of Child and Adolescent Psychiatry
<http://www.med.umich.edu/aacap/homepage/html>

American Association of Disabled Persons
<http://www.geopages.com/CapitolHill/1629>

American Psychological Society
<http://psych.hanover.edu/aps>

American Psychological Association
<http://www.apa.org/>

Angie Advice Column
<http://www.nomius.com/angie.htm>

Anxiety Disorder Association of America
<http://interport.net:80/~lindy/adaa.html>

Attacking Anxiety Video Documenting & Booklets
<http://www.rovers.net/~schweol>

Bipolar Network (Stanley Foundation)
<http://165.112.218.13>

Carter Center
http://www.cc.emory.edu/CARTER_CENTER/~scbio.htm

Center for Anxiety and Stress Treatment
<http://www.cts.com/~health/>

Center for Mental Health Services Research
<http://www.gwbssw.wustl.edu/~nethelp/cmhr/cmhr.html>

Center for Psychiatric Rehabilitation
<http://web.bu.edu/SARPSYCH>

CentralLink
<http://www.centralink.com>

Child Behavior Checklist
<http://salus.uvm.edu>

Cyber-Psych
<http://www.charm.net/~pandora/psych/index.html>

CyberPsychologist
<http://www.cyberpsych.com/>

Cybershrinks
<http://www.gate.net/~cyshrink>

Depression
<http://avocado.pc.helsinki.fi/~janne/asdfaq/>

Dr. Bob's Home Page
<http://uhs.bsd.uchicago.edu/~bhsiung/dr.bob.html>

Eating Disorder Resources on Internet
<http://www.nvg.unit.no/~cath/sf/ed.html>

Florida Mental Health Institute
<http://www.fmhi.usf.edu>

Forensic Psychiatry
<http://www.forensic.psych.com>

HabitSmart
<http://www.cts.com:80~habtsmrt/>

Help!
<http://www.io.org/~madmagic/help/help.html>

Helpnet
<http://www.offawa.net/~helpnet/>

International Society for the Study of Multiple Personality and Dissociation
<http://cedar.cic.net/~issd/>

Internet Medical and Mental Health Resources
<http://neamet.gnn.com/wic/med.21.html>

Internet Mental Health
<http://www.mentalhealth.com>

Institute of Psychiatry
<http://www.iop.bpmg.ac.uk/home/depts/library/ment.htm>

Instream Psychlink
<http://www.psychlink.com/>

Interpsych
<http://www.psych.med.umich.edu/interpsych/index.html>

Leonard Holmes
<http://www.psychology.com/holmes.htm>

Madness
<http://www.io.org/~madness>

MedWeb
<http://www.cc.emory.edu/WHSC/Lmedweb.mentalhealth.html>

Medical and Mental Health Resources
<http://www.realtime.nct/~mmjw>

Mental Health
<http://www.iop.bpmf.ac.uk/home/depts/library/ment.htm>

Mental Health Infosource
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Mental Health Policy Resource Center
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Mental Health Resources (Herb Stockley)
http://freenet.msp.mn.us/ip/health/stockley/mental_health.html

Mood Disorder
<http://avocado.pc.helsinki.fi:81/~janne/mood>

Myron D. Brenner
<http://www.doubleclickd.com/brenner.html>

National Alliance for the Mentally Ill
<http://www.caiss.com/vikings/nami/index.html>

National Crisis Prevention Institute
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National Institute of Mental Health
<http://www.nimh.nih.gov/>

Neuropsychology Central
<http://www.premier.net/~cogito/neuropsych.html>

New Consciousness Network
<http://www.gate.net/~miracles/>

New York PsychoAnalytic Institute
<http://www.interport.net/nypsan>

New York State Psychiatric Institute
<http://cpmcnet.columbia.edu/dept/pi/>

Online Psychological Services

<http://www.onlinepsych.com>

Orton Dyslexia Society

<http://pie.org/T3639>

Panic-Anxiety

<http://frank.mtsu.edu/~sward/anxiety/anxiety.html>

Psyc Grad

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Psych Scapes

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Rebus Institute

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Shyness Home Page

<http://www.shyness.com>

Social Worker Networker

<http://pages.nyu.edu/~mfh0446/>

Suicide Awareness

<http://www.save.org/>

Tipper Gore's HomePage

http://www.whitehouse.gov/White_House/EOP/VP_Wife/html/TIPPER.Home.html

Tourette Syndrome

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Trauma Page (Dr. David Baldwin)

<http://gladstone.uoregon.edu/~dvb/trauma.htm>

University of Michigan

<http://www.psych.med.umich.edu>

WPIC Library Mental Health Resources

<http://wpic.library.pitt.edu/psychiat.htm>

Mental Retardation

ADA and Disability Information

<http://wsl.databank.com/~adabbs/mrsites.html>

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<http://fohnix.metronet.com/~thearc/faqs/pamr.html>

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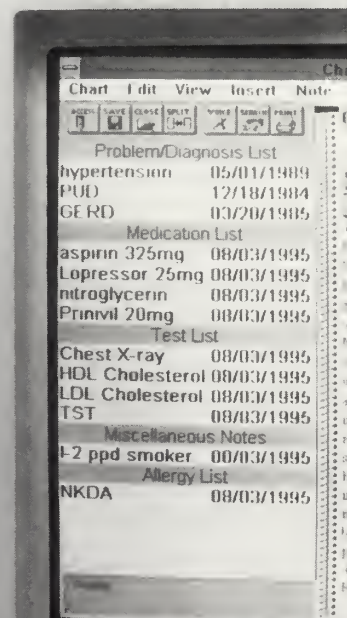
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The Price of Progress: How Much Does a Physician Organization Cost?

James H. Wilton

How much does it cost a group of physicians to form a physician-owned, physician-controlled organization for the purpose of risk-contracting, utilization management and quality management? This topic is currently receiving much attention around the state. Over the past few weeks we have heard numbers as high as \$25 million. We cannot imagine how any physician organization (PO) could spend (let alone need) that type of capital for start-up short of extreme extravagance or questionable management. One thing that doesn't confuse us is a rather insidious misdirection technique engaged in by some who wish to keep physicians under their control.

Since it is *physicians* who represent access to patients and hold the key to effective clinical cost control and utilization management, the dilemma for these nonphysician players becomes apparent. If they need access to patients or if utilization management and effective cost control are critical to their success, they must have access to the doctors who hold the key. How do they do that? One

option is control the doctors. But it cannot be direct control. Doctors are too independent a group for that. What about fear and barriers? That might work. For years one of the fear and barrier techniques was the idea that two physicians cannot talk about anything but a patient's treatment plan or the weather without running afoul of antitrust or fraud and abuse. Not only was that untrue, but with the recent modifications to the antitrust guidelines, a network which is properly established for the proper purpose need have few concerns whatsoever. What else might be put forth as a barrier? *Money!* If formation of a PO could be made to look prohibitively expensive, that would discourage movement. Who stands to win in that type of situation? Those who want control. Those who wish to assist in setting up these high dollar operations. They try to make capitalization so great a barrier to forming an independent physician association that it becomes cost prohibitive without a strong financial partner. Naturally they then self-sacrificially offer to be that partner ... for a share. Lip service is paid to independence, but the umbilical is never cut between the physicians and this financial partner.

But is this truth or fiction? How is a doctor to know? The best way we have found is simply: *ask questions!* Lots of questions. Ask for the reasons they say it will cost so much money. Where is the money going to

MED-NET OF DELAWARE is a subsidiary of the Medical Society of Delaware. It has been formed exclusively to assist Delaware physicians to form physician-owned, physician-controlled physician organizations, to contract with managed care companies for risk contracts, and to efficiently manage medical resources while delivering the highest quality medical care. Mr. Wilton is president and chief executive officer of MED-NET.

go? Can it be done less expensively? In Pennsylvania, for example, the PennMed Member Services Company (a subsidiary of the Pennsylvania Medical Society) has assisted in the development of over 30 POs. Each is either in or preparing to enter risk contracts with managed care companies. Not one of these organizations has cost the physicians who own them over \$70,000 in initiating costs from conception to full operation. There is an additional capitalization requirement for operating costs until capitated revenue begins which roughly equals the initial cost. In other words, the most expensive PO to date in Pennsylvania can be done for \$140,000 which covers all initiating and operating costs until capitated revenues begin to flow through the organization. As stated by Richard Shinto and Richard L. Tompkins, "The IPA is ... the least expensive organization to create, with most initiating costs ranging from \$50,000 to \$150,000. The IPA model becomes an attractive alternative when these development costs are compared with those of more integrated medical delivery systems, which have, in some cases, exceeded \$30 million."¹

It is also important to take a good close look at the entity that says it will cost so much. What do they have to gain? With whose interests are they primarily concerned? What does their model look like? Are they buying medical practices? Are they buying a computer system? Are they buying bricks and mortar? Are they applying for an insurance license? What is the regulatory environment in the jurisdiction from which the examples are originating? Do they have solvency and reserve requirements? The lesson of Coastal Physician Group, Inc., should not be lost.² Coastal saw the dream of a "physician-led revolution" turn into a nightmare. What began as a vision of building physician networks ended with the publicly traded company forced to abandon ancillary businesses, sell many of its clinics and rue the day it acquired its first HMO license.

The truth is that most of these things are not necessary for beginning a PO. The things that are necessary for managing risk-bearing contracts, such as a computer systems, administrative support and hands-on management assistance, can all be obtained and financed through the capitated contracts once

a revenue stream begins. These latter things are crucial for success, but not in development. The only real requirement for a PO is dedicated, committed physician leadership. Some of the systems that have required large initial capitalization or run into financial difficulty in the recent past have attempted to build their program from the top down rather than from the bottom up. When you try to put the top on the building before the foundation is laid, there is little doubt that great sums will be required. If, however, you methodically lay a solid foundation first, then what is built on top will be stable and lasting. These are mistakes to be understood and avoided. Each can be avoided with a properly laid foundation and the help of experienced and dedicated management assistance.

Once these questions have been answered, then get down to basics. As many are aware, a critical issue in risk contracting is ownership: ownership of the contracts, ownership of the data. So again, ask questions. Who owns the stock? Who votes the stock? Who is on the board? Who negotiates the contracts? Who signs the contracts? Who owns the contracts? Who owns the system? Who owns the data?

At any juncture in this process, if ownership is not physicians and *only physicians*, we heartily recommend that you raise an eyebrow and view any proposition with careful scrutiny.

MED-NET OF DELAWARE is able to help answer each and every one of these questions. We have been formed for the benefit of the physicians of Delaware and no other purpose. We are committed to beginning each local/regional undertaking with a solid physician's organization as the foundation. Should you desire any additional information on this topic or wish to schedule an educational presentation for your group, please do not hesitate to contact us.

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Dante Pigosi

E. Wayne Martz MD

When I finished residency in 1951, I knew absolutely nothing about opening or running an office, so I went into practice with a reputable, older doctor in Pittsburgh. At that time, the United Mine Workers was running a huge medical care program funded by a tax or "royalty" of 10 cents a ton on every ton of coal that came out of the ground. Almost any doctor in that area who wanted could see UMW patients and bill UMW Welfare and Retirement Fund. Since I saw UMW patients with my sponsoring doctor, I continued to see them when I opened my own office one or two years later.

The open panel concept didn't last long as it soon became evident that the fund was going bankrupt. It was being overused and misused. It was not surprising that some miners, if they didn't like their eye glasses or their back braces, simply went to another doctor and got different ones. It was surprising, though, when the UMW found itself billed for a second and even a third appendectomy or cholecystectomy on the same patient! They soon came out with a listing of the doctors whom they considered acceptable. As the list got shorter, they found their expenses diminished, and soon a relatively small number of doctors were taking care of most of their patients. Needless to say, this raised a bit of controversy, partly from miners whose favorite doctor was no longer listed, but also from doctors who found themselves cut off from a significant portion of their practices.

In some areas the UMW built their own clinics or offices, staffed them with family doctors and had specialists come in as needed on a contract basis. I tried this for awhile, one

day a week, but soon realized that my own overhead continued unchanged while I was working in their offices. I had to charge them enough to cover my overhead, which meant they were paying for it twice, if I charged fee for service, or I paid it twice if I negotiated a retainer based on their providing the office. In addition, my own patients resented my absence from my own office, and I had a lot of catching up to do the next day.

There were some parallels to what I see practitioners going through today. I eventually quit seeing UMW patients except for legal evaluations, but the doctors who seemed most content were the older doctors who took a full-time, salaried position with the UMW. Not very many of the younger doctors were willing to do that. In the first place, they did not trust the UMW enough to put their whole future in UMW hands, and secondly, they wanted the opportunity to increase their incomes by seeing non-UMW patients. They didn't want a cap or ceiling on them.

Many of the older doctors had been what we called "check off" doctors and had worked all their professional lives on a relatively fixed income. In the "coal patch", or small mining town, there was one mine and one doctor, though often one doctor covered several of these little communities. Every Friday the miners lined up in the building at the mine head and were paid, usually in cash, what was owed them based on the number of shifts they had worked, less what they owed at the company store and other charges. Just beyond the pay master was the person with the check off list — a list of the names of all the miners. If they wanted medical coverage (and they

usually did), they paid the nominal fee, usually 50 cents, and a check mark was placed beside their name. The money went to the doctor, and he was obliged to care for the families of all miners who had check marks by their names. It was pretty simple as a concept, and for the most part, it worked, at least as long as the mines worked. In hard times, the mine might work only 2 or 3 days a week, and there might not be enough to cover the bill at the company store, let alone the check off. The doctor might be faced with some difficult decisions when the wage earners had not checked off for several weeks, but as far as I am aware, they always took care of their check off families.

I was privileged to get to know some of those check off doctors, and they were a wonderful and interesting breed. One who still sticks in my mind after 45 years was Dante Pigosi. Dante was a medical machine. He would see patients hour after endless hour, usually well over a hundred a day. Any check off doctor seeing less than 65 a day was considered to be not carrying his share of the load. Dante had come to the USA from Italy

in his early teens, unable to speak any English. He went to work and he went to school, and he never quit until he had his MD from Pitt. In terms of native intelligence, he must have been genius level or very close to it. He knew all of his patients by name and their families and their medical histories. Dante taught me one thing, aside from what he taught by his example about what it means to be a man and to be a doctor.

He once sent me a patient in consultation who was a four plus hypochondriac. When I complained to him, Dante asked me a question, "Why do some hypochondriacs complain of headaches, and others of backaches, and still others indigestion or something else? There is something that focuses the patient's attention on that part or function. The fact that we can't identify it is our deficiency or the deficiency of the tools we have to work with. The patient is not to blame, nor is she imagining things. Look behind the hypochondriasis. She will some day get sick and die, and we will miss it because we didn't look." I've never forgotten that. It was good advice — I think.

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IN BRIEF

NIH Consensus Development Conference

We in Delaware are very fortunate in our geographic location for medical learning experiences. Not only are we within two hours traveling time of 23 university medical centers, but more importantly, what is potentially the greatest learning experience is free of charge and available in Bethesda. I am referring to the Consensus Development Conferences of the National Institutes of Health. These conferences bring together medical experts and others from far and wide (not Federal employees) to assess the safety and efficacy of drugs, devices and procedures and to arrive at a consensus statement about the disease/condition under consideration. These statements set the standard for current thinking and action.

There are three such conferences planned for this winter.

- 1) Breast cancer screening in women ages 40-49 — January 21-23, 1997
- 2) Interventions to prevent HIV risk behaviors — February 11-13, 1997
- 3) Management of hepatitis C — March 24-26, 1997

For more information contact Conference Registrar, 3202 Tower Oaks Blvd, Rockville, MD 20852. Or call (301) 770-0610, fax (301) 468-2245, e-mail: confdept@tech-res.com

Fellowship Earns Highest Level of Accreditation From National Healthcare Commission

The New England Fellowship for Rehabilitation Alternatives, Inc., a non-profit agency providing comprehensive mental health and addiction services, has earned Accreditation **with Commendation** from the Joint Commission on Accreditation of Healthcare Organizations. This is the highest level of accreditation and was achieved by only 22 percent of applicants nationally last year.

According to Joseph F. Dziobek, president and CEO of the Fellowship, it provides comprehensive, community-based clinical and support services for adults recovering from mental illnesses and addictions. Program components include structured residential programs, supported housing, Assertive Community Treatment Teams, non-hospital-based crisis diversion and Fountain House model clubhouses. Services include counseling, crisis intervention, intensive case management, vocational training, independent living assistance and a host of other community support services. The Fellowship operates two facilities in Georgetown, Delaware and one in Seaford, Delaware.

TRICARE Standard Champus Information Now Available on the World Wide Web

TRICARE Standard/CHAMPUS information is now available on the home page of the Assistant Secretary of Defense for Health Affairs: www.ha.osd.mil. This feature of the home page was made available on May 24, 1996.

Cutaneous Melanoma '96

The Skin Cancer Foundation is launching an unprecedented series of symposia to be held at major medical centers across the country. The first symposium, jointly sponsored by the Foundation and Memorial Sloan-Kettering Cancer Center, will take place on Saturday, December 7

at Memorial Sloan-Kettering. "Cutaneous Melanoma '96: A Clinical Symposium for Primary Care Practitioners" is targeted to general clinicians, including family practitioners, internists, obstetrician/gynecologists, pediatricians, nurse practitioners, and physician assistants.

For registration and further information, please contact:

Memorial Sloan-Kettering Cancer Center
Office of Continuing Medical Education
Box 31, 1275 York Avenue, New York, NY 10021
phone (212) 639-6754; fax (212) 717-3140

or:

The Skin Cancer Foundation
245 Fifth Avenue, Suite 1403, New York, NY 10016
Att: Cutaneous Melanoma '96
phone: (212) 725-5176; fax (212) 725-5751

Eleventh Annual Critical Care Medicine Course

Dumont, NJ — The Center for Bio-Medical Communication, Inc. (CBC), announces plans for "CRITICAL CARE MEDICINE '97: 11th Annual Review and Update," to take place at the Hyatt Regency, Washington, DC, April 30 - May 4, 1997.

Course Directors Drs. Henry Masur and Joseph E. Parrillo have designed the curriculum for the five-day course to provide a forum for a comprehensive, multidisciplinary review and update on the diagnosis, monitoring, and management of the critically ill patient. A distinguished 24-member faculty of nationally recognized leaders from the areas of critical care, cardiology, pulmonology, anesthesiology, infectious disease, and endocrinology will present such topics as: shock; mechanical ventilation; GI bleeding; hepatic failure; renal failure; antimicrobial management; cardiac arrhythmias; thrombosis; AIDS; congestive heart failure; blunt trauma; coagulation disorders; endocrine emergencies; seizures; and electrolyte emergencies. The conference has been endorsed by the Society of Critical Care Medicine.

This year, a unique feature again will be added to the regular program: optional evening sessions geared to preparing physicians for the Critical Care Boards and Recertification Exam will be offered. The focus of these sessions is examination-oriented to better equip attendees for passing the Boards.

Sponsored by the Center for Bio-Medical Communication, Inc., the course has been designated for up to 41.25 credit hours in Category 1 of the Physician's Recognition Award of the AMA. This program has been reviewed and is acceptable for 41.25 prescribed hours by the American Academy of Family Physicians.

Early-bird registration (on or before March 21, 1997) is \$795 for physicians and \$575 for physicians-in-training and other allied professionals. Course organizers have arranged reduced hotel rates for course registrants.

For further information, contact: Center for Bio-Medical Communication, Inc. Tel: (201) 385-8080; fax (201) 385-5650; or e-mail cbcbiomed@aol.com.



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The *Delaware Medical Journal* is a monthly publication of the Medical Society of Delaware. The *Journal* reaches approximately 75 percent of the state's physicians, as well as medical libraries, and hospitals; its circulation is approximately 1,600.

Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting.

Closing for space reservations is the first of the month, two months prior to publication. Closing for materials is the first of the month, one month prior to publication.

All advertisements are subject to approval by the Publications Committee of the Medical Society of Delaware.

For a media kit or for more information, call Heidi A. Sigmund at 302/658-7596 or 800/348-6800 (Kent or Sussex Counties).

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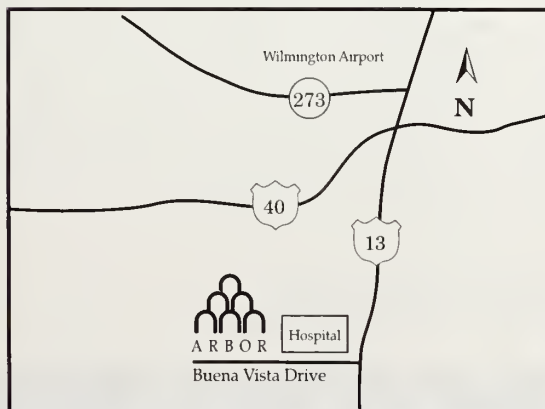
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